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SCOPE OF PUPIL PERSONNEL SERVICES.

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PART I OF THIS PAMPHLET DESCRIBES THE INTERPROFESSIONAL RESEARCH COMMISSION ON PUPIL PERSONNEL SERVICES, WHICH WAS STARTED IN 1962 BY THE OFFICE OF EDUCATION AND FINANCED BY THE NATIONAL INSTITUTE OF MENTAL HEALTH FOR A 5-YEAR PROGRAM. THE REST OF THE PAMPHLET DEALS WITH STATISTICS AND SPECIFIC PUPIL PERSONNEL SERVICES. OF THE 60,000 FULL-TIME-EQUIVALENT PUPIL PERSONNEL SPECIALISTS IN PUBLIC SCHOOLS, 27,180 SECONDARY SCHOOL COUNSELORS ENGAGE IN PRIVATE COUNSELING, GROUP COUNSELING, CONSULTATION, PLACEMENT, AND EVALUATION. THE MAJOR ADVANTAGE HELD BY THE 2,254 SCHOOL SOCIAL WORKERS IS THEIR KNOWLEDGE OF, AND ENTRY INTO, THE COMMUNITY'S SOCIAL RESOURCES. SEVENTY-SIX PERCENT OF THE SCHOOLS HAVE SPEECH AND HEARING SERVICES TO AID THOSE CHILDREN (5 PERCENT) WITH COMMUNICATION DISORDERS. OTHER SERVICES ARE PSYCHOLOGICAL, PSYCHIATRIC, NURSING, OTHER MEDICAL, AND ATTENDANCE. THE FORECAST FOR PUPIL PERSONNEL SERVICES IS THAT (1) THEY WILL BE IMPROVED WITH HIGHER STANDARDS FOR PERSONNEL, (2) UNIVERSITIES WILL EXTEND INTERDISCIPLINARY PROGRAMS, (3) CERTIFICATION WILL INCLUDE INTERNSHIP RATHER THAN TEACHING EXPERIENCE, (4) AIDES WILL BE USED FOR SUBPROFESSIONAL FUNCTIONS, AND (5) RESEARCH WILL BE INCREASINGLY USED. THIS DOCUMENT IS AVAILABLE AS FS 5.223--23045, FROM THE SUPERINTENDENT OF DOCUMENTS, U.S. GOVERNMENT PRINTING OFFICE, WASHINGTON, D.C. 20402, FOR $0.35. (PR)

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SCOPE OF PUPIL PERSONNEL SERVICES

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PART I—OVERVIEW

The Interprofessional Research Commission on Pupil Personnel Services was created because leaders in education and professional disciplines envisioned collaboration to improve service for school children. They were seeking to seal gaps, to replace competition with cooperation, and to stretch limited personnel to reach the maximum number of children. As the first chairman of the Commission, Dr. Hoch led it through its early struggles. Four research centers now bear witness to his leadership and professional talents.

FOREWORD

COUNSELING of children and consultation with teachers and parents are, to some extent, functions of guidance counselors, school social workers, school psychologists, attendance workers, speech and hearing clinicians, nurses, and other medical personnel. The overlap in the preparation and roles of these specialists has long been recognized. This publication not only presents the scope of pupil personnel services as they now exist, but also the forward look of professional concepts and some creative approaches to these services. It should serve as a basis to further clarify specific functions of each service and to develop optimum patterns of services in both elementary and secondary schools.

This bulletin provides information which will be helpful to school administrators and teachers as well as pupil personnel specialists. It should stimulate universities to critically examine current practices in graduate preparation programs, and help directors of pupil personnel services gain further insight into the self-image of each profession, in order to organize collaborative programs in their school systems.

Part I describes the Interprofessional Research Commission on Pupil Personnel Services (IRCOPPS) which is currently engaged in a broad research program in pupil personnel services, funded by a 5-year grant from the National Institute of Mental Health. This section also presents a statistical overview of pupil personnel services as culled from national surveys of the Office of Education and other sources.

Part II is a review of each service as seen by prominent representatives of national associations. With one exception, all of the contributors served as official delegates of their professions on IRCOPPS. Each writer presents his own point of view, recognizing that differences exist in programs of preparation and ways in which specialists work in schools. The evident overlap among the services contributes to the urgency for organizing pupil personnel services into collaborative programs.

Appreciation is expressed to each contributor for helping to clarify pupil personnel services as they exist today.

ARTHUR L. HARRIS,
Associate Commissioner
for Elementary and Secondary Education

PART I—CHAPTER 1

THE BIRTH OF A COMMISSION

By Erasmus L. Hoch, Professor of Psychology, the University of Michigan

The Interprofessional Research Commission on Pupil Personnel Services (IRCOPPS), initiated and fostered by the Office of Education, was organized in 1962 to conduct a systematic program of research and demonstration in pupil personnel services. IRCOPPS was conceived by a group of professional and educational associations deeply concerned with the provision and conduct of pupil personnel services.

Pupil personnel services follow a diversity of patterns. Though there is fair agreement on which professional groups constitute the services, there is less agreement on what the respective functions of each group are, and little agreement on which patterns of organization are most effective. These are major issues which IRCOPPS will consider in a large-scale program of interdisciplinary research.

The Commission, financed by the National Institute of Mental Health, is composed of 16 member associations, 12 of which are charter members:

American Association of School Administrators
American Medical Association
American Nurses Association
American Personnel and Guidance Association
American Psychological Association
American Speech and Hearing Association
Association for Supervision and Curriculum Development
Department of Elementary School Principals
International Association of Pupil Personnel Workers
National Association of Secondary School Principals
National Association of Social Workers
National Education Association
and
American Academy of Pediatrics
American Psychiatric Association
American School Health Association

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Council for Exceptional Children

On July 10, 1962, NIMH granted the Commission $1,324,326 in support of a 5-year program of research and demonstration. Consequently, four regional research and demonstration centers were established at the University of Maryland (the central office of IRCOPPS), the University of Michigan, the University of Texas, and the University of California at Los Angeles. Gordon P. Liddle of the University of Maryland is general director of the Commission, replacing Walter B. Waetjen who resigned to become vice-president of the University. Directors of the regional centers are James A. Dunn of the University of Michigan, Richard H. Byrne of the University of Maryland, John Pierce-Jones of the University of Texas, and Merville C. Shaw of the University of California at Los Angeles.

The respective aims of the Commission are to promote more effective pupil personnel services—

1. by providing through research a body of knowledge that will increase the effectiveness of all professions and services collaborating to provide the total learning experience,
2. by demonstrating efficient programs of pupil personnel services for various sizes and types of communities,
3. by carrying on and stimulating research on preventive mental hygiene related to the schools.

The Commission, aware of the numerous problems which must be solved, identifies at least 10 areas in which its program of research might advance. Following is a representative sample of some of the questions as contained in the original proposal of the Commission.

Questions in search of answers

Need for pupil personnel services

What is the causality of needs for pupil personnel services? How can a school system and a community determine what pupil personnel services are needed and in what proportions?

Children needing services

Which children who become problems after the third grade cannot be identified in a screening at the first, second, or third grade level? What kinds of children see themselves negatively but are seen positively by peers and teachers?

Evaluation and description of pupil personnel services

What are the measures of efficiency? What are the uses of dropout rates, reading disability data, teacher ratings, peer perceptions, IQ changes, college entrance rates, etc., as valid measures of the impact of pupil personnel programs? What are the criteria by which pupil personnel programs can be evaluated as part of the total school program? Should the criteria involve decrease in negative behavior—boredom, dropouts, underachievement, delinquency—or increase in positive behavior—broadening of interests, awakening of creativity, realization of potentials—or both?

Preventive mental health practices

What are the most effective practices for screening and early identification of "vulnerable" children who may require pupil personnel services? Are staff consultative functions more productive than direct contact with pupils in certain types of cases?

Functions and programing of pupil personnel services

What numbers of pupil personnel workers in the several professions are needed per thousand pupils in various kinds of schools and communities? To what extent are some pupil personnel functions more effectively served by group contacts than by individual contact?

Relation of pupil personnel services to instructional program

What organizational patterns promote maximum cooperation and most efficient collaboration between instructional and pupil personnel staffs? How can pupil needs discovered through pupil personnel services be fed back into program development and curriculum change?

School and community relations

What are good procedures for relating the school's pupil personnel services to the practicing professions serving the same children in the community? Are some services more effective if placed outside the school, e.g., in a community clinic?

Organization and administration

Where, when, and how are experimental innovations in the pupil personnel program most effectively introduced? What are the elements of a functional record system to serve the entire pupil personnel program? At what point does a pupil personnel program become too large to be directed effectively from the central office?

Intraprofessional problems

What kinds of motivation are most appropriate for effective work in schools? What areas of preparation are and/or should be common to the various professional persons working in pupil personnel services? What are the relative status levels within the professions of positions in a school setting as compared with other professional settings?

Interprofessional relationships

Does the pupil personnel worker see himself primarily as a member of a team or as an individual practitioner? How can the professions involved develop a language of communication that would use com-

mon terms and avoid conflicting usage and misunderstanding?

The projected five-year program of research and demonstration includes the following:

1. A set of field study and demonstration programs of pupil personnel services to fit various types and sizes of communities.
2. A national study of children's needs for pupil personnel services giving comparable data concerning various regions and types of communities as well as various types of learning difficulties or handicaps.
3. A survey of the characteristics of the various pupil personnel specialists as well as the differing patterns of organization under which they work.
4. An intensive study of certain exemplary pupil personnel service programs in terms of types of children served, measures of effectiveness, distribution of resources, and administration of the programs.

In an extensive background paper prepared for the Commission by Robert J. Havighurst, Paul H. Bowman, and Fred C. Proff, there is a section which explores the possibility of systematically evaluating organizational models. Among the several models mentioned are: (a) a pupil personnel department headed by a director of pupil personnel services; (b) a program administered by a department of special education; (c) contractual consultation in which the non-instructional services are provided on a part-time basis by professional consultants outside the school system; (d) an "anarchical" system with little or no formal structure.

The Commission recognizes the need for sound research and demonstration programs. These are made possible by the regional centers' investigative facilities, their network of relations with school systems, and liaison between pupil personnel specialists and their colleagues in education. The whole of it seems a good formula—as it must have seemed to the National Institute of Mental Health when its advisory panel granted the financial support which brought the Commission into existence. In so doing, the Institute wished neither to claim the Commission as its own nor to discourage it from seeking other and further long-term support.

THE ROAD AHEAD

The research and demonstration program of its regional centers is but the first project of the Commission. Its overall mission is many pronged and, with further sources of support, can thrust in several directions. Even now it is richly endowed. It has the consultative talents of the several

professional associations. It can enlist the services of staff of the U.S. Office of Education and the National Institute of Mental Health. It is in a position to sponsor conferences bringing together researchers, specialists, and educators. It can arrange to be heard at national conventions and in the pages of the professional journals. The Commission states that:

> The basic purpose of the pupil personnel services is to help insure for every child—the gifted, the normal, and the handicapped—the maximum opportunity for a successful school experience.

In reporting statistics for pupil personnel services, terminology often clouds the picture. Social workers are called visiting teachers in some school systems, while teachers of homebound students are designated as visiting teachers in other systems. Counselors at the elementary school level include psychologists and social workers. In different States, the graduate preparation of school psychologists ranges from 1 year to a doctoral degree. Attendance workers may be highly trained as social workers or may lack specialized preparation entirely. Similarly, other pupil personnel specialists represent a range of preparation to meet different State certification requirements to work in public schools.

PART I—CHAPTER 2

FIGURES AND FORECASTS

By Louise Omwake Eckerson, Specialist, School Personnel Services, and Hyrum M. Smith, Chief, Guidance Procedures and Techniques, U.S. Office of Education

An estimated 60,000 full-time equivalents* with professional background other than, or in addition to, teaching now serve as pupil personnel specialists in public schools. They include guidance counselors, school social workers, attendance workers, school psychologists, speech and hearing clinicians, nurses and other health specialists.[1]

*Two half-time specialists equal one full-time equivalent specialist.

[1] Numbers of pupil personnel specialists reported in this chapter may sometimes be at variance with figures in subsequent chapters. Discrepancies may be explained by the use of estimates in the absence of exact data and by the difficulty of gathering data on a national scale. Also, it should be remembered that all of the services are constantly growing, and that there is a time lag in the collection and reporting of statistics.

MAJOR SOURCES OF DATA

Office of Education report on school personnel in 1961–62 [2]

The Office of Education published an annual report on numbers of public school personnel employed in 1961–62. The data were collected from State departments of education, with the exception of those in Alabama, Maryland, Missouri, Oregon, South Dakota, and Virginia. The total figures, therefore, must be interpreted as representing 44 rather than 50 States. This source of data will be referred to as the report of 1961–62.

[2] U.S. Department of Health, Education, and Welfare, Office of Education. *Statistics of State School Systems, 1961–62.* OE-20020-62. Washington: U.S. Government Printing Office, 1964.

Office of Education survey of pupil personnel services in public elementary schools in 1962–63 [6]

The Office of Education survey of 1962-63 was based on responses of principals of public elementary schools with enrollments of 100 or more pupils. Survey questions related to pupil personnel services available through the school system or outside agency at no cost to pupils. A stratified sample of 5,504 schools was used, drawn from a universe of approximately 53,500 public elementary schools. This source of data will be identified as the survey of 1962-63. Since this survey did not report numbers of pupil personnel specialists per se working in the schools, figures are not comparable to those of the 1961–62 report.

Collection of guidance data under the National Defense Education Act in 1962–63 [6]

The Office of Education data pertaining to high school counselors in public schools included all counselors, regardless of financial support by the National Defense Education Act. Statistical reports were collected annually from State departments of education beginning in 1958. Forecasts were made for elementary school guidance personnel. This source of data will be called the NDEA report.

FIGURES RELATING TO PUPIL PERSONNEL SPECIALISTS

Since it is necessary to draw upon different sources of information in determining numbers of pupil personnel specialists, the reader will have to evaluate the nature of the data (specialists and services), completeness of responding agencies (States), recency of collection of data, and reporting of actual, inflated, and projected numbers.

Secondary school counselors

A count (NDEA report) of secondary school counselors in public schools made for the school year 1962–63 gave 27,180 counselors (full-time equivalents). Of this number, 17,928 were full-time counselors, an increase of 143 percent

[6] U.S. Department of Health, Education, and Welfare, Office of Education. *Guidance Services in Elementary Schools: A National Survey.* (OE-25045) Washington: U.S. Government Printing Office, 1966.

[6] U.S. Department of Health, Education, and Welfare, Office of Education. *Commitment to Youth: A Report on Five Years of Progress in Guidance, Counseling, and Testing Under Title V, Part A, of the National Defense Education Act.* (OE-25039.) Washington: U.S. Government Printing Office, 1964.

over the 1958 (pre-NDEA) figure. The total number of counselors, both full and part time, was 38,150.

In 1962-63 the counselor-student ratio (based on all secondary school students) was 1 to 530 against 1 to 960 in 1958-59. The usual recommended ratio is 1 counselor to 250-300 pupils. If this ratio is used, approximately 60,000 counselors will be needed by 1970 to serve secondary school students.

Elementary school guidance consultants

The survey of 1962-63 indicated that 12,000 elementary schools (over 100 pupils) had the services, for at least 1 day per week, of a "child development consultant" (former teacher with preparation in guidance, psychologist, or social worker. These noninstructional services may be interpreted broadly as guidance services. The percents of schools in four geographical areas that received these services were distributed as follows:

	Percent
North Atlantic	31
Great Lakes and Plains	25
Southeast	11
West and Southwest	30

Of schools that did not have "guidance" services as defined above, 75 percent indicated that such services were needed.

The desired ratio of guidance consultants to elementary school pupils is variously estimated by experts as 1 to 300-600, depending upon characteristics of the student body and the availability of other services. Some schools may need one consultant for only 100 pupils. However, if the ratio of 1 to 600 is used, 44,000 guidance consultants are needed now to serve pupils in kindergarten through grade 8 in elementary schools and 54,000 will be needed in 1970.

Of 154 universities which reported that they offered the master's degree in elementary school guidance, most did not have programs which were essentially different from those provided for secondary school counselors. In a 1964 survey, only 45 graduate programs could be identified as programs specifically organized for the preparation of guidance personnel in elementary schools.[6]

Likewise, where State certification exists for elementary

[6] Nitzschke, Dale F., and Hill, George E. *The Elementary School Counselor: Preparation and Functions*, Athens, Ohio: Center for Educational Research and Service, Ohio University, 1964.

school guidance personnel, the requirements closely resemble those for secondary school counselors. Several States, however, have already set up certification requirements after studying the special functions of elementary school guidance, and most of the other States are currently working on plans in the wake of recent Federal legislation.

Due to the recognition that guidance in high school was offered too late to save dropouts and motivate underachievers, the National Defense Education Act was amended in 1964 to include elementary schools. It provides limited funds to support guidance programs in all elementary grades, and to conduct institutes to give professional guidance preparation at this level. This legislation promises to stimulate programs of guidance in elementary schools as it has at the secondary level.

School psychologists

The 1961–62 Office of Education report found 2,409 psychologists (full-time equivalents) working in public schools. The 1962–63 survey found 62 percent of elementary schools (over 100 pupils) using psychological services. Less than one-fourth of the principals in these schools reported that such services were adequate.

School social workers and attendance personnel

Full-time social workers (visiting teachers) numbered 2,254 according to the 1961–62 report. In an increasing number of school systems, attendance workers are qualified social workers or have some background in social work. There were 5,432 full- and part-time attendance workers in 1961–62.

The Office of Education survey indicated that in 1962–63, 53 percent of public elementary schools (with enrollments over 100 pupils) had the services of social workers. One fourth of these reported that the services were adequate. Attendance services were provided in 78 percent of elementary schools and were reported adequate by the majority of their principals.

School nurses

There were 13,228 full- and part-time nurses employed in public schools in 1961–62, according to the report. In 1962–63, 73 percent of elementary schools (over 100 pupils) had services of nurses; in these schools, 48 percent of the principals described the services as adequate.

Physicians and psychiatrists

Full- and part-time physicians and psychiatrists employed by public schools were grouped together in the 1961–62 report and totaled 5,540. Only 377 child psychiatrists now are certified by the American Board of Psychiatry and Neurology and 344 more are in training. Hence, the actual number working in schools as well as the source of supply are extremely limited, but a rapid growth is forecast.

The survey of 1962–63 indicated that 57 percent of public elementary schools (over 100 pupils) received services of physicians and 37 percent received services of psychiatrists at no cost to pupils. Though 39 percent of principals judged their medical services as adequate, only 12 percent rated psychiatric services as adequate. Medical and psychiatric services limited to examination or consultation were included in the above figures. There is no way, of course, to estimate services donated by many members of the medical professions directly to children without the knowledge of school staff.

Speech and hearing clinicians

In the 1962–63 survey, 76 percent of the principals reported that their elementary schools (over 100 pupils) received services in speech and hearing. These services were considered adequate in almost half of the schools. Next to attendance services, help in speech and hearing was the pupil personnel service most frequently offered in public elementary schools.

VARIETY AND COMBINATIONS OF PUPIL PERSONNEL SERVICES

In 1962–63, 87 percent of principals in elementary schools (over 100 pupils) stated that three or more services were available at no cost to their pupils. Even three services represent the nucleus of a coordinated pupil personnel program. About 16 percent of elementary schools in the survey had all of the services listed, while 2 percent reported none.

Guidance, psychological, and social work services—services with a major interest in emotional problems of children—were available in 31 percent of elementary schools; none of these three services was offered to children in 16 percent of schools. The six services most commonly included in pupil personnel programs—guidance, psychological, social work, nursing, speech/hearing, attendance—were available to children in 26 percent of public elementary schools.

AGENCIES PROVIDING PUPIL PERSONNEL SERVICES

Pupil personnel services were provided in 1962–63 at no cost to pupils by various agencies in addition to the school system. The following table shows the extent to which each service (in elementary schools with over 100 pupils) was financed by (1) school systems, and (2) outside agencies, such as social welfare agencies, public health departments, mental health clinics, and child health clinics.

Attendance, speech/hearing, and nursing services were most frequently available to school children; psychiatric services which may have been limited to consultative services were least often provided. Outside agencies offered social work services to about one-fourth of elementary schools, and psychiatric, medical, and nursing services to about one-fifth.

Percent of public elementary schools receiving pupil personnel services from different agencies

Agencies providing services	Pupil personnel services							
	Guidance (on assigned time only)	Psychological	Social work	Psychiatric consultation and/or treatment	Medical examination and/or treatment	Nursing	Speech/hearing	Attendance
School systems	40	38	15	8	26	48	54	71
Outside agencies	3	14	27	22	20	18	12	2
Both school systems and outside agencies	7	10	12	7	11	7	10	4
Schools receiving service	50	62	53	37	57	73	76	78
Schools not receiving service	50	38	47	63	43	27	24	22

FREQUENCY OF PUPIL PERSONNEL SERVICES IN SOCIOECONOMIC AREAS

Pupil personnel services should be available at no cost to all school children when they need them. However, it is conceivable that such services are needed most by children in families of low socioeconomic status. The following table gives the percents of elementary schools (over 100 pupils) in specified socioeconomic areas (as described by principals) in which the individual services were available in 1962–63.

In general, more elementary schools in extreme socioeconomic strata (advantaged and disadvantaged) received pupil personnel services than schools in average socioeconomic strata. Guidance and psychological services were provided most frequently in advantaged areas, while social work services were offered more often in disadvantaged areas. Speech and hearing services were available in nine-tenths of elementary schools in advantaged communities. No medical services were offered to pupils in 36 percent of schools in disadvantaged areas.

Percent of pupil elementary schools in different socioeconomic areas receiving pupil personnel services

Socioeconomic status of families	Pupil personnel services							
	Guidance (on assigned time only)	Psychological	Social work	Psychiatric consultation and/or treatment	Medical examination and/or treatment	Nursing	Speech/hearing	Attendance
Advantaged	60	87	56	45	60	84	91	83
Above average	55	76	59	40	56	80	85	80
Average	49	60	51	36	57	71	75	76
Below average	47	55	51	32	56	69	69	78
Disadvantaged	53	68	66	52	64	79	74	88

GEOGRAPHICAL DISTRIBUTION OF PUPIL PERSONNEL SERVICES

The 1962–63 survey of public elementary schools provided a geographical distribution of pupil personnel services. The following table shows, by region, the percent of elementary schools (over 100 pupils) which received the several services at no cost to pupils.

Geographical regions [1]	Pupil personnel services							
	Guidance (on assigned time only)	Psychological	Social work	Psychiatric consultation and/or treatment	Medical examination and/or treatment	Nursing	Speech/hearing	Attendance
New England	51	63	52	47	88	86	75	79
Mideast	46	89	63	54	89	91	89	89
Great Lakes	56	71	53	41	47	79	79	81
Plains	43	57	51	34	44	65	73	70
Southeast	41	38	48	26	52	50	61	75
Southwest	58	40	48	22	44	73	70	71
Rocky Mountains	54	55	58	40	43	82	77	71
Far West	62	86	58	39	49	86	90	75

[1] See next page.

NORTH ATLANTIC

New England:

- Connecticut
- Maine
- Massachusetts
- New Hampshire
- Rhode Island
- Vermont

Mideast:

- Delaware
- District of Columbia
- Maryland
- New Jersey
- New York
- Pennsylvania

GREAT LAKES AND PLAINS

Great Lakes:

- Illinois
- Indiana
- Michigan
- Ohio
- Wisconsin

Plains:

- Iowa
- Kansas
- Minnesota
- Missouri
- Nebraska
- North Dakota
- South Dakota

SOUTHEAST

Southeast:

- Alabama
- Arkansas
- Florida
- Georgia
- Kentucky
- Louisiana
- Mississippi
- North Carolina
- South Carolina
- Tennessee
- Virginia
- West Virginia

WEST AND SOUTHWEST

Southwest:
- Arizona
- New Mexico
- Oklahoma
- Texas

Rocky Mountains:
- Colorado
- Idaho
- Montana
- Utah
- Wyoming

Far West:
- California
- Nevada
- Oregon
- Washington
- Alaska
- Hawaii

OE REGIONS
- North Atlantic
- Great Lakes and Plains
- Southeast
- West and Southwest

OBE REGIONS
- New England
- Mideast
- Great Lakes
- Plains
- Southeast
- Southwest
- Rocky Mountains
- Far West

The Southeast trailed behind other geographical regions in the frequency of guidance, psychological, nursing, and speech and hearing services, and tied with the Southwest in social work. The Mideast and Far West fared exceptionally well in psychological services; the Mideast and New England in medical services; the Mideast, New England, and Far West in nursing; and the Far West and Mideast in speech and hearing. Psychiatric services were found most frequently in the Mideast and New England regions.

STATE CERTIFICATION FOR PUPIL PERSONNEL SPECIALISTS

As of 1963, 49 States and territories had established certification requirements for secondary school counselors. Although the appropriate professional associations (American School Counselor Association and the Association for Counselor Education and Supervision) have recommended 2-year graduate programs of preparation for counselors, this goal is far from attainment. A 1-year master's degree in guidance is the usual requirement for State certification, but some States have yet to achieve this level.

Twenty-five States certified school psychologists, counseling psychologists, or psychometrists in 1963. School social workers were certified in six States, and school nurses in three.[6]

The trend is toward State certification with higher requirements in an increasing number of specialized areas. As certification is extended to cover more pupil personnel specialists, State departments of education are adding personnel to their staffs to give leadership and supervision in the several professional areas. It is envisioned that schools of the future will have a full complement of pupil personnel specialists at the local, State, and National levels.

[6] Camp, Dolph. *Guidance Workers Certification Requirements.* OE-25005A. Washington: U.S. Government Printing Office, 1963.

COORDINATION BY PUPIL PERSONNEL DIRECTORS

The emotional state of the schoolchild has been claimed as a subject of study by all of the pupil personnel specialists. Which specialist first sees the youngster with emotional problems may depend upon the overt manifestations: physical symptom, speech disorder, aggressive behavior, truancy, failure in school, etc.

The source of the child's trouble and the symptoms displayed may be of major concern to several pupil personnel specialists. Cooperation among these specialists, therefore, requires coordination by one person, a director, who gives leadership to a team of specialists.

Usually this director of pupil personnel services has come directly from one of the disciplines or from education. However, some universities are now offering graduate programs which are organized to give broad preparation to prospective candidates. Such programs will probably increase as school

systems search for directors to organize and administer pupil personnel services.

The Office of Education survey of 1962-63 indicated that 43 percent of elementary schools were in school systems in which three or more professional services were directed by one person. Such beginnings of coordination may well lead to a total pupil personnel program.

Frequently, school systems have sought help in developing pupil personnel services from State departments of education; State personnel are beginning to provide this leadership. To aid State directors of pupil personnel services, the Council of Chief State School Officers published a policy statement setting forth responsibilities which State personnel should assume for the maximum development of children.[1]

Now, the biggest thrust of all has come from professional and educational associations responsible for supplying and using noninstructional services for school children. Thus, the Interprofessional Research Commission on Pupil Personnel Services is engaged in research, funded by the Federal Government, to clarify and suggest effective ways of coordinating and administering services for children.

FORECAST

Pupil personnel services will be improved, extended, and coordinated. As pupil personnel specialists enter schools in larger numbers, most of them will be better qualified; counselors and social workers will have 2 years of graduate work, and attendance workers will be trained in social work. School nurses will have baccalaureate degrees, and psychologists will have doctoral degrees.

Universities will implement interdisciplinary programs for the preparation of pupil personnel, especially counselors. Staff members from the departments of education, psychology, sociology, anthropology, economics, and health will cooperate in an effort to broaden the behavioral science background of specialists who will be concerned with the development of the whole child in modern society.

State certification will be revised to include internships in schools, in lieu of teaching experience, for counselors and other specialists. Also, provision will be made for orienting pupil personnel specialists such as nurses, physicians, and psychiatrists to the school setting.

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[1] *Responsibilities of State Departments of Education for Pupil Personnel Services.* 1201 16th Street NW., Washington: Council of Chief State School Officers, 1960.

Aides will be trained to expand the services of all pupil personnel. Just as the nursing profession pioneered in training practical nurses and nurses' aides to perform subprofessional duties in hospitals, all professions will innovate in the selection, training, and supervision of aides to help pupil personnel specialists in the schools. When aides are provided to relieve specialists of routine and subprofessional functions, the role of well-prepared specialists will change. In general, their new roles will permit more time for direct services to children and their parents, and consultative services to the school staff.

Through preservice and inservice education, members of each profession will become better oriented to other disciplines, and will develop mutual respect which is essential to collaboration. Through collaboration, specialists will strive to meet the developmental needs of all children without duplication of effort in behalf of some, and neglect of others.

Some services will remain community based, but the trend will be toward provision of pupil personnel services by the school system. Under one director, the various members of the pupil personnel team will function in a coordinated manner. Directors will be former specialists, usually with doctoral degrees in pupil personnel services.

Research will alert school administrators to rich potential in the contributions of pupil personnel specialists. Also, research conducted by some specialists may reveal negative as well as positive effects stemming from traditional practices, or associated with innovations such as: early admission, ungraded schools, grouping systems, team teaching, new reading techniques, and programed learning, as well as experimental or pilot projects envisioned in supplementary educational centers made possible by the Elementary and Secondary Education Act of 1965. Creative research, then, is the key to better education through the maximum use of pupil personnel services.

PART II—REVIEW

Guidance services have progressed far beyond the original concept of helping high school students choose vocations. In addition to vocational guidance, these services now include educational and personal guidance and extend throughout all educational levels. In theory, guidance is being viewed as a lifetime service, from preschool to retirement, with the goal of increasing each individual's capacity for self-direction.

PART II—CHAPTER 1

GUIDANCE SERVICES

By Robert O. Stripling, Professor of Education, and David Lane, Associate Professor of Education, University of Florida

While it is now generally acknowledged that guidance services are indispensable at all levels of education, their implementation began as a response to the needs of secondary school youth and those entering the labor market. By the turn of the century the technological advances which originated in the industrial revolution had resulted in a degree of complexity in the world of work that made occupational choice and planning difficult and confusing.

Vocational guidance

Vocational guidance as a systematic process began in 1908, with the founding of the Vocation Bureau in Boston by Frank Parsons. During the early years, guidance practitioners were concerned with assisting young men to obtain initial employment or to advance from a particular job to a more promising one. Gradually, these pioneer counselors realized that their counselees had needs which demanded broader definition, and that career counseling could be effective only when attention was paid to all aspects of the individual's life. Vocational guidance over the years became, in Super's words:

> the process of helping a person to develop and accept an integrated and adequate picture of himself and of his role in the world of work, to test this concept against reality, and to convert it into a reality, with satisfaction to himself and benefit to society.[1]

Testing

Present day guidance services trace their origins to several developments in modern history. These services have been facilitated and greatly influenced by the emergence of standardized testing as an increasingly significant factor in

[1] Super, Donald E. "Vocational Adjustment: Implementing a Self-Concept." *Occupations*, vol. 30, November 1951, pp. 88-92.

modern society. In the latter half of the 19th century, Sir Francis Galton in England and other scientists in Europe and America began to experiment with the scientific measurement of human characteristics. At first these efforts were largely confined to simple psychomotor acts. J. McKeen Cattell seems to have been the first to use the term "mental test," in 1890. However, it was Alfred Binet and his colleagues, in France, who launched the modern era of testing. Gerberich et al., observe that as early as 1895—

> Binet and Henri described tests of memory, imagination, attention, comprehension, suggestibility, and aesthetic appreciation that were forerunners of the Binet-Simon scales of the Twentieth Century.[1]

Binet and Simon produced their first intelligence scale in 1905. During World War I the first *group* intelligence scales emerged, in response to the need for an efficient method of classifying draftees. These developments were followed during succeeding decades by a formidable proliferation of standardized testing instruments. The characteristics to which testmakers directed their attention included not only intelligence but achievement, special aptitudes, interests, values, attitudes, and temperamental tendencies.

The rapid development of testing contributed significantly to the guidance movement in our fast-growing public school system. Teachers and counselors were provided with more precise information than had previously been available to assist them in understanding children's capacities and needs. Thus, it became possible to plan educational experiences with more sensitivity to individual differences than had been true in the past. However, the perspective of our accumulated experience with this vast array of tests, scales, questionnaires, and inventories suggests that these devices promised more than they have subsequently been able to fulfill. Standardized testing has, for several years, been undergoing a critical reappraisal, and counselors are becoming more keenly aware of the limitations of these instruments as aids to the guidance function.

Mental health movement

The tremendous breakthrough in understanding behavior, which stemmed from the emergence of modern psychiatry and clinical psychology, has been fundamentally significant to the development of modern guidance and other pupil personnel

[1] Gerberich, J. Raymond; Green, Harry A.; and Jorgensen, Albert N. *Measurement and Evaluation in the Modern School.* New York, David McKay, 1962.

services. The insights into the dynamics of behavior, attributable to the development of psychoanalysis as a technique for studying behavior and as a method for treating emotional disorders, have spread far beyond the consulting room. Indeed, many of the technical terms of psychoanalysis have become embedded in our language.

Since the early impact of Freud's work, the understanding of behavior has been deepened and extended by many psychologists, especially by those who have emphasized the central role of the individual's perceptions as the principal basis for his behavior.[3] The work of these psychologists has been broadened by sociologists, anthropologists, and social psychiatrists who have studied the influence of environmental factors on mental health. Out of these researches and theoretical explorations has emerged a variety of important techniques for studying students, including standardized group and clinical tests, case history techniques, anecdotal records, home visit procedures, and sociometric methods.

GUIDANCE TECHNIQUES

The concept of guidance has evolved from that of a service to be rendered at crucial points in children's growth to a view that guidance is a continuous, developmental process. Over the years the school has come to be acknowledged as the central and coordinating agency in the guidance program. The increased recognition of the need for organized programs at the elementary level has led the elementary school to share the guidance role formerly assumed by the secondary school.

Counseling

The central service of the guidance program, especially at the secondary school level, is counseling. Counseling is a kind of helping relationship in which two people communicate about plans, decisions, feelings, and attitudes. One of the participants, the counselee, is personally involved. The other, the counselor, puts aside his own problems for the time being and brings his resources to bear on the concerns of the counselee, who is encouraged to enjoy the luxury of paying full attention to himself. This encouragement is not offered in an attempt to develop self-centeredness, but rather in the belief that full and free self-expression is the basis for self-understanding and healthy behavior. When an individual has come to understand his own needs and his own nature, he is freed of the necessity to engage in fruitless and excessive

[3] Combs, Arthur W., and Suygg, Donald. *Individual Behavior*. New York, Harper & Brothers, 1959.

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introspection.

While the counselor is never indifferent to a counselee's immediate tasks and choices, such as selecting a college or a job, he is nonetheless primarily concerned with assisting the counselee toward increased self-understanding and maturity. One of the axioms of counseling is that its impact is intended to increase the individual's capacity for self-direction. The counselor strives to work himself out of a job with each particular counselee.

Small group counseling and group procedures

One of the exciting current trends in guidance is small group counseling, an approach which holds promise of enabling counselors to achieve some objectives more effectively than through individual counseling. A small group setting sometimes enables a counselor to reach a student who has not responded to individual counseling; the presence of others affords the student an opportunity to make the helpful discovery that his problem is not unique, that others have similar problems.

Small groups provide an authentic situation in which students can learn by experience new insights and new ways of coping with other people. Since most of our difficulties, conflicts, opportunities, and challenges occur in relationships with other people, it is no wonder that group situations, supervised by a sensitive and competent leader, provide for significant growth in interpersonal effectiveness.

Some of the functions of the guidance program which most clearly lend themselves to group procedures include orientation of new pupils from feeder schools to junior or senior high schools; exploration of common developmental experiences, such as boy-girl relationships; and exploration of special problems which a particular segment of the student body may be facing at a given time, such as underachievement and temptation to drop out of school.

Group procedures have held an attraction for many counselors and administrators because of the perennial hope that fewer staff members might serve a larger number of students than is possible with individual counseling. Experience has shown that group methods do not actually make possible a more economical counselor-student ratio. However, there is evidence that a combination of the two methods is more effective than either one alone. Many efforts to provide group guidance have failed because the sessions were used to force points of view of the administra-

tion or faculty on students. Students must feel free to explore ideas that are of concern and interest to them; they must feel free to express their opinions without being challenged by persons in authority. The leader must be able to facilitate and not dominate group discussions.

Consultation with Parents and Teachers

One of the most effective ways available to counselors for accomplishing guidance objectives is consultation with parents, teachers (especially of elementary school pupils), and other adults who are cooperatively concerned with children's growth. However, the function of consultation in guidance has begun to receive systematic attention only in recent years. It is increasingly being considered a complex and challenging professional skill with unique features which call for special emphasis in counselor education, practice, and research.

The dearth of available professional literature on work with parents indicates that, in practice, counselors have relatively neglected this area—perhaps because of an uncertainty concerning the adequacy of their skills for the task.

On the other hand, it is sometimes assumed that conferring with parents involves merely an extension of the process of counseling, that the procedures the counselor uses in his encounters with students can be applied without modification in interviews with parents. Experience sometimes seems to substantiate this assumption, since a parent occasionally welcomes an opportunity to obtain counseling help for his own problems.

Far more often, however, the parent quite rightly sees himself as a colleague of the teacher and counselor in the process of helping the child or adolescent grow up—indeed, as the central adult in this helping process. If both parties to a parent-counselor conference proceed on this assumption, it provides the basis for a fruitful consultation. The behavior of the student becomes the focus of the conference, and the consultant (counselor) and consultee (parent) work together to understand the student's behavior and to make plans for providing necessary guidance. The counselor assists the parent to gain insight which will enable him to deal more effectively with his child in the future.

Counselors may work with parents in a variety of ways and for a variety of purposes. Conferences may take place at the school or at the parent's home. The occasion may be in response to an immediate problem, deadline, or crisis, or it may be a scheduled part of a planned developmental ap-

proach in which periodic conferences are arranged between counselor and parents throughout the school years.

Teachers, particularly those who work with younger children, have long acknowledged that they often wage an uphill fight against home influences which may be at cross-purposes to the efforts of the school. Counselors who have developed consulting skills may find that conferences with parents are a significant way of breaking through this barrier. This guidance service seems especially promising at the elementary level, since it is during these years that children are most deeply and widely influenced by their families.

It is highly probable that consultation with teachers will occupy a larger proportion of the school counselor's time and attention in the years ahead.

Consultation may extend the counselor's influence by increasing the capability of the teacher to perform his guidance role. The purpose of consultation is not to make the teacher into a counselor but to help him increase the insight and skills which are an integral part of his teaching responsibility.

The process of consultation is appropriate to any guidance function to which teachers can make a contribution. The counselor can assist teachers with interpretation of test data and other background information, with individual counseling problems, with the use of occupational information, and with group procedures. Counselors will also find occasion to serve as consultants to administrators and to other specialists on the school staff, such as librarians and nurses.

SUPPLEMENTARY SERVICES

Though counseling, group procedures, and consultation are the primary guidance functions which involve direct, skilled, professionally grounded interaction between the counselor and other people, several important guidance services supplement and support them.

Appraisal

An important foundation of the guidance program consists of background information which is accumulated about each pupil and made available for use in counseling as well as in certain other services, such as placement and research. Most of the work involved in collecting, recording, and filing these data can and should be handled by clerical personnel, though the counselor determines what data are to be collected and by what methods, and also studies the data for use in the counseling process.

The counselor is usually delegated leadership responsibility in developing a testing program, in cooperation with the administration and the teaching staff, so that appropriate tests may be administered at strategic steps in the development of children through the school years. For example, measures of academic aptitude and achievement are often administered at times when important decisions or curricular arrangements are about to be made. Measures of academic capacity may be administered just prior to the first grade (reading readiness), the fourth grade (beginning of the intermediate years), the seventh grade (in preparation for exploring various curricular tracks in junior high school), and the ninth grade (when important curricular decisions, both general and specific, must be made).

The counselor should avoid assuming unilateral control over the planning and administration of the testing program. All too often it becomes the "counselor's testing program." Teachers should take an active part in selecting tests and using test results so that these devices can serve their essential purpose in the total educational process. Here, the counselor can best make his contribution as a coordinator and consultant.

The counselor also serves as coordinator and consultant in such appraisal procedures as making anecdotal records and using rating scales, autobiographies, sociograms, and other devices for child study. For example, anecdotal records and sociometric data can assist the counselor in selecting students when planning for group procedures.

Placement*

The trend in placement, or helping high school graduates and early school leavers obtain employment, is toward a joint effort with the local office of the State employment service. Placement may involve consultation with teachers, especially those who teach vocationally oriented courses, as well as counseling students concerning sources of information, job choice, and job interview skills. In addition, the counselor participates in bringing employers and applicants together.

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*In the elementary school, "placement" refers to the assignment of a child to an appropriate ability group, grade level, or special class. The counselor is frequently part of a team that considers multiple characteristics of a child before determining the group in which he will make the most progress. At the secondary level, placement may relate to full- or part-time jobs, grouping in programs or tracks, or admission to college.

Evaluation

Evaluation is a method of obtaining periodic checks on the effectiveness of *all* the guidance services. Evaluation sometimes takes the form of followup surveys of graduates and early school leavers. Such data often help suggest gaps in the guidance program. Other evaluation procedures may be based on analyses of records of early leavers, the rate of academic failures, the number of scholarship winners, referrals to agencies outside the school, and similar data.

PROFESSIONAL ACTIVITIES

Since 1958, leaders in various parts of the United States have been critically examining the role and preparation of the school counselor. Several studies have stimulated controversy and action at the local as well as the national level. Perhaps no emerging profession has ever been shaken so drastically at its roots in so short a period of time.[4] By 1964, policy statements relating to the preparation of secondary school counselors had been issued after prolonged and searching study by four professional associations:

1. American Personnel and Guidance Association (APGA).
2. American School Counselor Association (division of APGA).
3. Association for Counselor Education and Supervision (division of APGA).
4. Counseling Psychology (division of the American Psychological Association).

This concentrated activity by professional associations was aimed at improving the quality of counselor preparation and the services of counselors to high school students. The official statements carried recommendations addressed to institutions that offer programs in counselor education, and to public secondary schools in which counselors work.

During the early 1960's APGA took official note of the growing number of guidance programs in elementary schools and initiated a study of the movement across the Nation via questionnaire and conferences. The subsequent statement, *Dimensions in Elementary School Guidance*, was developed as a "consensus" report upon which to base further study.

Soon ASCA and ACES, the two divisions of APGA concerned with elementary school guidance, collaborated on a

[4] Loughary, John W.; Stripling, Robert O.; Fitzgerald, Paul W., editors. *Counseling: A Growing Profession.* Washington, D.C., American Personnel and Guidance Association, 1965.

policy statement with reference to the role and preparation of elementary school counselors. Giant steps were thus taken to place elementary school guidance on a firm foundation which would permit flexibility in gro..th in line with research developments.

TRENDS IN THE PREPARATION OF ELEMENTARY AND SECONDARY SCHOOL COUNSELORS

Studies during the last few years indicate a widely acknowledged core of professional preparation for both elementary and secondary school counselors. This core includes work in such fields of study as human growth and development, including personality dynamics and learning; statistics, measurement theory, and measurement practice; an introduction to data processing and programing techniques; counseling theory and practice; and vocational development theory.

There is also a trend toward broadening the base of preparation in the behavioral sciences for the school counselor because graduate level preparation in basic psychology and counselor education is not considered sufficient.[8] Such areas as cultural anthropology, sociology, comparative religion, philosophy, economics (including labor management trends), and political science have much to contribute to the preparation of the school counselor. There is also growing awareness of the need for emphasis on laboratory experiences and supervised practice in counseling and small group work.

Programs of graduate preparation should be offered only in institutions of higher learning which have strong graduate programs in related areas, and can serve enough students to offer a year-round program in counselor education, staffed by professionally qualified, full-time faculty members whose major responsibility is the education of counselors. Such institutions should also have close cooperative working relationships with elementary and secondary schools where counseling candidates can participate in internship experiences under the supervision of qualified staff members.

Though counseling services in elementary and secondary schools should be available to all children and youth, the school counselor should develop understandings and skills which will assist him in working with various identifiable subgroups of the school population. Some of these groups

[8] Lloyd-Jones, E., and Westervelt, E. M., editors. *Behavioral Science and Guidance.* New York, Bureau of Publications, Teachers College, Columbia University, 1963.

are the culturally disadvantaged,[6] potential early school leavers,[7] intellectually gifted students who are underachieving,[8] and school youth who desire opportunities in technical and vocational education,[9] as well as the parents of these children.

SUPERVISION OF GUIDANCE SERVICES

As the nature of the role of consultation has become more clearly defined, there has been a trend toward viewing supervisory personnel in school counseling as consultants, rather than as supervisors. Also, there has been a trend toward sharing the consulting role among State departments of education and local school personnel. State departments of education have expanded supervisory services in the areas of elementary and secondary school counseling and guidance from 69 (full-time equivalent personnel) in 1958–59 to 300 in 1963–64. This increase has been paralleled by the increase of consultants at the systemwide level. The coordination of counseling and guidance services within the framework of pupil personnel services is needed at the local school level. Increasingly, it is recognized that a coordinator of guidance services should have an earned doctor's degree with a major in counselor education.

CERTIFICATION OF SCHOOL COUNSELORS

At present, 47 States offer certification for school counselors, with requirements varying widely from several graduate credit hours to a master's degree. There has been a tendency away from listing specific courses toward requiring more general areas of competency for the school counselor. Also, there has been a trend toward insisting that institutions of higher learning assume greater reponsibility for the endorsement of applicants for State certification in

[6] Bernard, Harold W., "Socio-economic Class and the School Counselor." *Theory Into Practice*, vol. 2, February 1963, pp. 17–23.

[7] Stripling, Robert O., "Professional Preparation of Counselors: Implications in Regard to School Dropouts." *Guidance and the School Dropout*. Washington, D.C., National Education Association and the American Personnel and Guidance Association, 1964.

[8] Miller, Leonard M., editor. *Guidance for the Underachiever with Superior Ability*. U.S. Office of Education Bulletin 1961, No. 25, OE–25021. Washington, D.C., U.S. Government Printing Office, 1961.

[9] Venn, Grant. *Man, Education and Work: Post Secondary Vocational and Technical Education*. Washington, D.C. American Council on Education, 1964. Borow, Henry, editor. *Man in a World at Work*. Boston, the Riverside Press, 1964.

school counseling and guidance.

Classroom teaching experience has become less important as a requirement for certification in school counseling. While the idea is sound that the school counselor should understand the processes of education and the school program, there are differences of opinion as to how such understandings can be satisfactorily achieved. Some have suggested that there may be a more efficient way of orienting the school counselor to the total school setting than requiring him to spend 1 or more years in actual teaching. For example, the State of Florida requires the certified school counselor to have had 3 years of teaching, and undergraduate internship in teaching, or an internship in school counseling, of which a minimum of one-half may be in a clinical setting.[10] Another trend relates to certification at the end of 1 year of graduate work in counselor education as provisional, whereas certification as a professional counselor would be acknowledged at the end of 2 years of graduate work.

Individuals and professional groups have expressed concern over the relatively low standards of certification for school counselors in many States. One objective of State certification should be to protect both students and parents against inadequately prepared school counselors. The report from the Division of Counseling Psychology [11] includes the following statement:

> States need to be courageous enough to set standards which emphasize quality, even if such standards may, for a while, result in a shortage of certified people.

[10] Florida State Department of Education, *Requirements for Teacher Certification.* Tallahassee, Fla., The Department, Mar. 10, 1964.

[11] Division of Counseling Psychology. *The Scope and Standards of Preparation in Psychology for School Counselors.* Washington, D.C., American Psychological Association, 6 p.

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School social workers, often called "visiting teachers," are concerned with the whole range of social, economic, and intellectual differences among children. They may work with disadvantaged youngsters from various ethnic groups, as well as with children who suffer from academic pressures placed on them in suburban schools and homes.

PART II—CHAPTER 2

SOCIAL WORK SERVICES

By JERRY L. KELLEY, Assistant Dean, School of Social Work, University of Washington

SCHOOL SOCIAL work began about 60 years ago in the Eastern part of the United States. As pointed out by Lide, this service originated from a mutual need faced by both social workers and educators. Schools began employing "visiting teachers" to work with truant children, and social workers began involving the schools in efforts to help deprived children.[1]

Though school social workers, at that time, were concerned primarily with the culturally deprived, they now deal with the entire range of individual differences in children. In highly endowed schools, social workers are more often engaged in intensive counseling with teenagers who reflect the stresses of high social and academic expectations—those children who develop internally directed rather than overt patterns of maladjustment.[2]

In any school, regardless of grade level, there are children with problems that reflect communities with problems. Over the years, visiting teachers have reached out for specialized knowledge and skills in order to better help school children adjust and succeed. Realizing the necessity of such knowledge and skills, many States now require or recommend that people filling these positions hold the master of social work degree. The National Association of Social Workers, in a statement titled, "Professional Qualifications for School Social Workers," stresses that holders of the degree must be oriented to and knowledgeable about the school as a social institution. Schools of social work are facilitating this dual

[1] Lide, Pauline. "Determining the Present Function of the School Social Worker." *Helping the Troubled Child.* New York, National Association of Social Workers. 1959.

[2] Kelley, Jerry L. *Children with Problems.* Washington, D.C., National Association Journal. January 1962.

emphasis. Currently, there are an estimated 150 to 200 graduates each year who have had at least 1 school year of field training in public schools. In addition, many other social workers are recruited into the school setting and make the necessary adaptation through inservice training or additional education.

The school social worker has four major areas of function according to Smith [3] and Kelley.[4] He is a *caseworker* who counsels with students and their parents. He is a *collaborator* who works cooperatively with other members of the school staff. He is a *coordinator* who serves as an agent to bring school and home, and school and community into better working relationships. He is a *consultant* who is available to confer with other staff members even though he may not be directly involved with students or their immediate problems.

The casework method of counseling is highly developed by the social worker since social work education and practices place more emphasis on counseling than is true of most pupil personnel specializations. In counseling, the social worker's focus on strengths (growth potential) is eminently compatible with educational goals. He has a professional optimism which is consistent with the general perception of the school experience as an opportunity to find and develop potential, rather than eradicate disease.

The social worker's traditional view of a client's total situation led to emphasis on interdisciplinary collaboration long before the "team" concept became popular. The social worker expects to share concern and responsibility with others and is skilled at helping to clarify the respective roles.

The total perspective of the social worker is valuable in consultation services. His knowledge of human development and methods of helping children enable him to aid teachers in their relationship with students.

Perhaps the social worker's most clearly seen advantage is his knowledge of and entry into the myriad of organized social resources of the community. He knows the system and often is in the most advantageous position to seek help from other professionals in referral, collaboration, or consultation. Often he can be directly helpful to the school administrator in respect to interrelationshps of school and agency. Finally, there is a highly predictable competence

[3] Smith, Hyrum M. "Pupil Personnel Services." *School Social Work—A Service of Schools*, U.S. Office of Education Bulletin 1964, No. 15, OE–31007, 1964, pp. 16–25.

[4] Op. cit., p. 1.

which the school social worker represents: his graduate training is standardized and equivalent from school to school, and from State to State.

THE EDUCATION OF THE SCHOOL SOCIAL WORKER

The standard education for a school social worker is graduation from an accredited school of social work, a 2-year graduate course of study. There is no preprofessional curriculum in social work that is required for admission. Generally speaking, schools of social work look for students with a broad liberal arts background and quality of academic performance or potential. In addition, they screen all applicants carefully to assess personal suitability for the profession.

Supplementary to the master of social work degree is an orientation to and knowledge of the public school. This background preparation may be variously acquired through inservice training during employment in a school, field work in a school as part of the graduate program, or course in education.

The masters degree program specifies three curricular areas: social welfare policy and services, human behavior and the social environment, and methods of social work practice. In addition, the social work graduate is required to spend at least 1,000 hours in field training which places emphasis on:

1. Use of self as the nearly exclusive instrument of help (no tests, health examinations, etc.).
2. Reliance upon the professional relationship as the essential means of effecting change.
3. Focus upon the support of strength (rather than correcting defects).
4. Perspective of the total situation (treating the whole child).
5. Selective referral (to school and community agencies).

THE POTENTIAL OF THE SCHOOL SOCIAL WORKER

Traditionally, school social work services have focused primarily on casework and there is no reason to expect that the need for such individualized help will diminish. However, current trends in both education and social welfare

augur and almost demand more extensive and creative use of social workers by the schools in individual and group counseling services and joint school-community involvement.

Individual counseling services

The push for academic excellence, the pressure of greater pupil population, and the desire for prevention of problems have moved schools to extend their counseling services both laterally and vertically. As more and more schools employ elementary school counselors, a typical social worker may ask, "Why substitute counselors for social workers?"

One answer lies in the recognition that elementary school counselors are potential allies—additions, not substitutions. There are counseling tasks related to educational readiness and progress, for example, which do not require the particular skills of the social worker. In fact, they may be better performed by someone more familiar with teaching, testing procedures, and other guidance techniques. As is presently true in many high schools, the counselors themselves may become the chief sources for referral of students to social workers. In addition, the wise administrator will welcome the opportunity to improve counseling services in general through the use of social workers in inservice training programs for both teachers and counselors.

Group counseling services

Teachers are masters of the group instructional process, while social group workers are masters of the group interactional process. The school, unlike other institutions, embodies formal and informal groupings of youngsters, yet the skill of the social group worker in promoting social growth has had only the most tentative testing in the school.[5] In group work, there is a whole vista of potential for reaching some hard-to-reach students, and for reaching *more* students who need social help. The employment of trained group workers by schools will almost inevitably occur. All social workers have some skill with groups; hence, even those whose greatest skill is in casework can begin to extend services to groups.

School-community involvement

This is the area with perhaps the most-exciting potential of all. The widespread concern about juvenile delinquents,

[5] Vintner, Robert D., and Sarri, Rosemary C. *Group Work in the Public School. A Research Report.* Paper presented at the National Conference on Social Welfare, May 1964. Mimeographed.

dropouts, culturally deprived, and unemployed youth has led to a wave of new programs, culminating for the moment, in the antipoverty measures.

In the common search for resolutions to these problems, collaboration between the fileds of social work and education is accelerating. There is mutual need and reciprocal gain. Soon, if it has not already occurred, social work specialists in community organization will be employed by schools to maximize this dual relationship. The old and honorable function of the school social worker as the liaison between the school and the troubled child will be enlarged to include all children and the whole community.

Compulsory school attendance protects the right of the individual to an education despite the neglect or apathy of his parents or the impact of negative factors within himself, or in his home, school, or community. The emphasis of attendance services has moved from the exercise of legal authority to the prevention of problems which cause children to stay out of school.

PART II—CHAPTER 3

ATTENDANCE SERVICES

By ALICE C. SHELDON, Director, Department of School Attendance and Work Permits, Public Schools of the District of Columbia

THE FIRST compulsory school attendance law was passed in Massachusetts in 1852. Its aim was to keep young children out of the New England factories by making school attendance compulsory for children up to 14 years of age. Other States soon followed with enactment of similar laws. However, there was much child labor abuse, and public opinion was still mixed as to the value of education for all children. In many instances, schools lacked methods of accurate child accounting and the necessary personnel to enforce laws, even when they were adequate.

By 1918, all the States had passed compulsory school attendance laws and the statute books throughout the United States proclaimed the belief of its people that each child not only had the right to benefit from an education but also the obligation to secure this advantage.[1]

It was not until the middle 1930's that most of the States had adequate legal provision for sound attendance enforcement procedures. These laws contained three necessary elements: compulsory school attendance until at least age 14, legal requirement for a census (child accounting), and provision to pay personnel to work especially with children having school attendance problems.

Conflicts and problems which inevitably arose led to the appointment of attendance workers to enforce the attendance

[1] *State Legislation on School Attendance.* Circular No. 573, Washington, D.C.: Office of Education, Department of Health, Education, and Welfare, January 1959.

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laws. Thus, it was recognized that a child is dependent upon his parents and the authorized agents of the community for the fulfillment of his potential by attending school. Where the parent fails, there must be a substitute community agent, or the child is automatically excluded from the benefits to which the State entitles him because of his very existence.

There also must be, for an increasing number of children, an agent who can help the child overcome obstacles and free him to accept educational opportunities. Unless there is a guarantee of intervention for each child, there is no real universal education.

CAUSES OF SCHOOL ABSENCE

School absence is not a simple matter of illness or truancy, but a complex problem with numerous dimensions. It reflects many subtle facets of human behavior, and the advantages and disadvantages of environment and cultural conflicts. It also involves academic failure.

Attendance services, in view of the foregoing, cannot be concerned only with the physical return of the absentee to the school. To be effective, they must be geared to motivate and enhance the aspirations of the absentee, and overcome a vast array of human and environmental problems which interfere with regular school attendance. Attendance services must frequently establish a sense of educational value and develop individual responsibility.

FUNCTIONS OF ATTENDANCE WORKERS

Attendance programs offer a wide range of services. They usually vary, however, by size of school district and by location in an urban, suburban, or rural area.

Short-term service

Parents and children are interviewed in their homes, and if necessary, help is provided on a short-term basis. Schools are informed of the findings, and recommendations are made by the attendance worker to school personnel.

Continued service

The attendance worker identifies absentees who need more intensive assistance. The cooperation of community agencies is enlisted or the attendance worker resolves the problem through the resources of his own agency or through special programs of the school system and the community.

Casework service

The attendance worker who has professional training in social work provides an intensive service for chronic absentees (and their families) with severe problems. The caseload (usually more limited than that of the regular attendance worker) consists largely of multiproblem families and those families who have not been accepted by or who have refused to accept assistance from community agencies for the benefit of their children.

Mobile group service

One or two attendance workers move about the community during school hours, providing immediate service to pupils who are on the street or in public places.

Juvenile court service

Chronic absentees who fail to respond to regular attendance services are referred to the juvenile court by attendance personnel. The help of the court is sought in protecting the child's right to an education. Attendance personnel may serve as liaisons between the juvenile court and the school system in cases where children have been delinquent outside of school.

Consultant service

In some school systems, attendance workers are assigned as consultants to assist principals and other school personnel in setting up and maintaining school programs that will prevent absence, and also provide special assistance to absentees in the school setting.

Service to unmarried parents

Attendance personnel refer unmarried parents of school age for special education programs, and in some cities, provide casework service. Generally, this is done in cooperation with other school personnel and with departments of health and welfare, hospitals, and police.

School dropout programs

In most school systems, attendance workers cooperate with guidance counselors and other school personnel in identifying and helping potential dropouts.

Child accounting

Attendance personnel are usually responsible for records

and files which list admissions, transfers, and discharges, as well as followup services related to this responsibility.

Employment certification

Frequently, the attendance department issues employment certificates to children who wish to work and who meet the requirements of the State and Federal child labor laws.

Miscellaneous services

Attendance departments may offer services relating to tuition investigations, physically or mentally handicapped children, emotionally or culturally handicapped children, children without legal settlement and children suspended from school. In some school systems, attendance personnel serve in a guidance or counseling capacity.

The Council of Chief State School Officers lists the functions of school social workers and attendance workers separately.[2] However, attendance workers who are educated to the professional level possess social work skills, and many perform school social work services under various titles.

The council lists the following professional services for which attendance personnel should be responsible:

1. Leadership in a program to promote positive pupil and parent attitudes toward regular school attendance.
2. Assistance to teachers in the early identification of patterns of nonattendance indicative of inadequate pupil adjustment.
3. Early professional action on problems of nonattendance, involving a casework approach to the pupil's problems; parent contacts; and cooperation with teachers, other pupil personnel workers, and appropriate community agencies.
4. Supervision of the school's program of child-accounting, including the school census, issuance of employment certificates, and registers of attendance.
5. Constructive use of authority pertaining to the enforcement of the school attendance laws of the State.[3]

[2] *Responsibilities of State Department of Education for Pupil Personnel Services*, 1201 16th Street NW., Washington, D.C.: Council of Chief State School Officers, 19 0, p. 18.

[3] *Ibid.*, p. 11.

CERTIFICATION OF ATTENDANCE WORKERS

By 1950, nearly all State certificates to discharge the responsibility of an attendance worker required a minimum of an A.B. degree. However, with the growth of professionalism and the recognition of skills necessary to work effectively with children, there has been an increasing interest in adding graduate courses in social work to the license provision for attendance workers.

For some time to come there probably will be no clearcut pattern over the country for a certificate in attendance work, primarily because attendance is a matter of State or local control.

CASELOADS

The adequacy of attendance services is related to the caseload factor as well as to the professional competence of workers. All studies of pupil-worker ratios have been affected by the lack of uniformity in reporting the number of pupils served. Many studies have simply compared the number of attendance workers to the total school population. When such total enrollment figures include kindergarten or a city junior college, the actual ratio of attendance workers to pupils is inaccurate. Until there are fewer variables in the statistics used, caseload studies will have to be evaluated with caution.

Another factor affecting the ratio in attendance services is the length of the workday of attendance personnel, which varies widely. Frequently, attendance workers, home and school visitors, visiting teachers, or school social workers engaged in attendance work have the same workdays as teachers; longer workdays are required in many cities and States. There is evidence of a trend to increase the workday and workyear for attendance workers, enabling them to serve families after the close of the school day and during the summer.

TITLES FOR ATTENDANCE WORKERS

The titles of personnel engaged in school attendance enforcement programs vary greatly, but there has been a marked trend toward using the title "school social worker" in recent years. Formerly, the most common title for this service was "visiting teacher." The extensive range of titles and the predominance of school social worker and visiting teacher are noted in a study by Dr. Robert B. Rowen, director of School Social Work in the New Jersey State Department of Education:

Title	Frequency
School social worker	58
Visiting teacher	41
Visiting counselor	4
School adjustment counselor	4
Guidance counselor	3
Home and school visitor	3
School counselor	3
Child welfare counselor	2
Elementary school social worker	2
School welfare counselor	1
Elementary school counselor	1
Elementary counselor	1
Welfare counselor	1
School-court liaison worker	1
Pupil personnel worker	1
Public welfare worker	1
Caseworker	1
Counselor	1
Visiting teacher social worker	1
School counseling consultant	1
Social worker	1
Guidance consultant	1
School social worker consultant	1
Adjustment teacher	1
Psychiatric social worker	1
Welfare worker	1
Attendance officer	1
Counselor teacher	1
Teacher of juvenile adjustment	1
Total	140

In general, when there is a school social worker and no other attendance worker, the school social worker is responsible for attendance enforcement. Conversely, when a school system has only attendance workers under different titles, the attendance worker functions as the school social worker.

THE INTERNATIONAL ASSOCIATION OF PUPIL PERSONNEL WORKERS

The International Association of Pupil Personnel Workers was founded in 1911 as the National League of Compulsory Education Officials. The name of the organization was subsequently changed to the National League to Promote School Attendance. This name revealed the chief interests and concerns of the membership who were directly involved with all aspects of the problem of school attendance.

As a result of the growing professionalism of workers and the geographical extension of its membership, a new name, International Association of Pupil Personnel Workers, was adopted in 1956. It is believed that this name reflects more

accurately the professional concerns of the members, recognising that children with problems of school attendance will continue to be the primary focus of the association. However, it is not only the child who is physically absent that needs attention, but also the deviant child with special needs. He, too, comes under the newly defined responsibility of the professional attendance worker or school social worker. The role of legal authority is now viewed as a therapeutic tool to be used with care and related to the broad needs of the child with problems.

Psychologists are almost universally accepted today by school systems as important specialists used in a clinical capacity. However, their professional preparation enables them to offer a broader service. Applying research conducted by psychologists may increase understanding of how children learn, and also build better mental health in children and school staff.

PART II—CHAPTER 4

PSYCHOLOGICAL SERVICES

By FRANCES A. MULLEN, Assistant Superintendent of Schools, Chicago City Schools, Chicago, Ill.

SCHOOL PSYCHOLOGY has a venerable and distinguished history, usually dated from the psychological clinic founded by Lightner Witmer in 1896 at the University of Pennsylvania, and the Bureau of Child Study established in the Chicago public schools in 1899. Since then, on a gradually expanding basis, psychologists have worked day by day in school systems, grappling in a down-to-earth fashion with problems faced by teachers. But until after the Second World War, programs remained confined to large cities and a few wealthy suburban districts.

Twenty years ago, most teachers and administrators knew little of the services psychologists could render, the public far less. Psychology was too often perceived as an esoteric discipline. The image of psychology as a magic wand for the cure of all personality difficulties might be attractive, but the corollary of a magic key to unlock closed doors and provide understanding of people (perhaps more intimately than they wanted to be understood) was fearsome. Such images have almost disappeared as the rapid expansion of psychological services in postwar years has brought a realistic picture of the potential contributions and the limitations of psychology in schools.

In a survey of all 50 States and the District of Columbia, the number of school psychologists was reported to have increased from 520 in 1950, to 2,724 in 1960, or more than 500 percent. In 1950, 22 States reported no school psychologists; in 1960, only four.[1]

[1] Magary, James F., and Meacham, Merle L. "The Growth of School Psychology in the Last Decade," *Journal of School Psychology*, I, Jan. 1963, p. 5–13.

THE CLINICAL FUNCTION

Today, the clinical function remains the predominant reason for the employment of school psychologists. The great majority of them devote most of their time to individual case studies of children referred because of learning problems, and to work with school staff, parents, community agencies, and pupils.

A clinical case study is not routine psychometrics, but a professional task which is time consuming, varied, and which calls for the application of basic theory and the insight of experience in the interpretation of data. An individual test of intelligence to verify or correct the less valid data of group tests or teacher judgment is a frequent ingredient, but only as part of any case study. Such a test must be carefully selected by the psychologist according to the age, disabilities, and needs of the child. In addition, the psychologist observes the child in life situations: in conversation, in play, in the hallways, on the playground, and in the classroom. He collects data from and shares data with the child's teachers, physician, parents, and others who may be able to help. He studies the development of the child, securing as much data as he can on the health history beginning with prenatal days, the developmental history in preschool days, the school history, the pattern of friends, and relations with adults and peers. He uses further psychological instruments to gain insights on special aptitudes, interests, and personality characteristics. He is concerned about physical coordination; he looks for evidence of sensory defects, or clues to a possible perceptual handicap. Also, he considers the child's cultural background.

After the information is gathered, it is interpreted, not by the psychologist alone, but in discussion and conference with those most concerned. In some cases, the teacher, administrator, school nurse, school social worker, guidance counselor, attendance worker, et al., may sit down to a formal staff conference with the psychologist, the parent, and concerned community workers in order to arrive at a synthesis of understanding and recommendations. More often, however, the psychologist accomplishes as much of this consultation as he can, less formally, in two-way conversations and interviews, in phone calls, or in small group meetings.

One of the most common referrals to the school psychologist is the child being considered for placement in a special class for the mentally handicapped, gifted, emotionally disturbed, brain injured, or other types of exceptional children.

A class for the mentally handicapped, for instance, is a good learning environment for the child who is basically mentally handicapped and will not progress beyond a given level of academic achievement. However, it is the wrong place for a child whose present retardation in school subjects is due to cultural deprivation. He needs, primarily, to have his curiosities stimulated, his experiences broadened, his motivation toward achievement heightened, and remedial instruction provided. Likewise, it is the wrong place for a child whose potential is temporarily obscured by emotional problems, perceptual or other specific handicaps, or masked by *petit mal* seizures or drug therapies. The differential diagnoses involved are not simple. Emotional disturbance can easily masquerade as a mental handicap. The migrant slum child whose brief experiences in a variety of schools have left him convinced of his own stupidity can present a rather convincing picture of mental retardation if probings for the unused capacities are not made. Nothing less than a complete case study can justify a serious decision concerning a child's educational career. Reevaluations every few years are equally important to insure fairness to the maturing child.

Some children have to be excused from school attendance because of mental immaturity or a complex of factors which make it impossible for the school to serve the child. Here, too, is a crucial decision, not one that the psychologist makes alone, but one to which he has much to contribute. A thorough case study may reveal remediable conditions, may help the parent to guide the child to better development, or may suggest ways not previously considered by which the school can serve the child.

Frequent referrals are made of children known to have good intelligence, but who present general or specific learning problems. The child who does not respond to instruction in reading profits from a diagnostic reading evaluation and a complete case workup; the child whose immature, halting, or indistinct speech does not respond to the attention of the classroom teacher or speech therapist needs study; so does the child who is good in all subjects except spelling or arithmetic, or who has some other specific block. Also, a study is indicated for the child who did good work last year and now slides by at a minimally acceptable academic rate, perhaps daydreaming, or having occasional spells of sullenness or anger. The child who is chronically truant, who demands excessive attention, who is deliberately aggravating to teacher or classmates, or who is excessively shy or anxious may be

referred. The child who never gets his work done because of a compulsive demand for perfection needs diagnosis as much as the child whose work is excessively slipshod and careless.

No school system has enough psychologists to do a thorough professional case study of all children who present problems in the school setting. Each school must set its own priorities, depending upon needs, psychological services available, other pupil personnel services available, and special abilities and aptitudes of the staff.

Work with teachers

To be effective, the psychologist must involve the teacher throughout the case study. The psychologist helps school staff to describe pupil behavior in operational rather than judgmental terms, to formulate the problem clearly as seen in the classroom, to be more discerning in discriminating serious symptoms from the less serious. As data from various sources are accumulated, the teacher should have an opportunity to react and to assist in the interpretation. The greater the involvement of the teacher in the process of formulating recommendations, the more likely those recommendations will be carried out effectively. Ideally, there should be two or more case conferences—one early in the case study and one late in the process—attended by a selected group of the people most concerned, particularly the teacher and the administrator. Frankly, this is seldom possible. The psychologist is aware of possible negative as well as positive reactions to his inquiries and his implications. He is aware of differences in the readiness of both teachers and parents to accept a new point of view. He knows that some teachers have professional training in mental health and that others, though not skilled in the latest psychological lingo, have acquired a real insight into child development and child needs. However, he hopes that as he and the staff work together toward the solution of the problems of one child, many teachers will grow in ability to understand and handle other children.

Work with parents

The diagnostic and treatment aspects of the psychologist's work may become more entwined as he moves from the teacher to the parent. From the parent, the psychologist gains insight into the cultural level of the home, the language, and experiential handicaps the child may have suffered, the pressures on one child for achievement, or the despair and

hopelessness that holds out no real goals to another.

The parent of a child with a problem seeks help whether he admits it or masks it by overt hostility or indifference. Even though he is assured that an initial conference is exploratory only, and that no recommendations have been made, he goes away from the session more or less able to cope with his problems—seldom, indeed, with no change. As the case study proceeds toward plan formulation, the more the parent can be a part of the process, the more likely he will be able to cooperate with the school and to modify his own actions or attitudes, if necessary. Little is accomplished by announcing decisions to the parent; someone must help him work through the problem. Frequently, this is the task of the psychologist.

Work with pupils

Some counseling, even some psychotherapy, is inextricably bound up in the process of the complete case study. To obtain useful diagnostic information about the pupil, the psychologist has to gain his confidence by establishing a warm, friendly relationship. As the pupil talks about his problem and his previous school and community experiences, or as the young child plays freely in the clinic playroom in the presence of an accepting and sympathetic adult, he is experiencing therapy.

The pupil is entitled to an interpretation of the results of the various tests and examinations to the extent that he is able to understand them. The older child and youth participate in making plans. Even in situations where the psychologist does not plan to see the child again after the case study, or until a reevaluation is planned or requested, he is aware of the therapeutic aspects of his rather prolonged relationship with the pupil during the case study. The psychologist's training in counseling and psychotherapy is used from the beginning.

In general, the school is not the proper setting for extended psychotherapy. A proper climate is more likely attained in a clinical setting outside of the school. However, much counseling that could well come within the definition of psychotherapy is and necessarily must be done in the schools by a variety of persons—the teacher, the guidance counselor, the principal, or whoever establishes a confidential relationship with the child. The psychologist has training in this area, and because of the start made during the case study process, he can, and frequently does, carry on brief and informal contacts that provide support and confidence for

the child.

Although informal counseling is the most frequent pattern, there are school based clinics in several school systems where more formal continued therapy is carried on by one or more of the child guidance team. There are instances of play therapy groups for disturbed young children, of therapeutic clubs for group work with adolescents, and of regularly scheduled treatment conferences. In some schools, the psychological staff is expected to devote a considerable portion of its time to therapeutic counseling with pupils, though this remains the exception. Even if schools believe that they should offer therapy, few have sufficient psychological staff to do so. If continuing counseling is to be given to a child in school, staff time must be specifically alloted for this purpose.

Work with other staff personnel

Inherent in what has been said is the necessity for close working relationships, for face-to-face communication to the maximum extent possible among all the staff involved with a given child. The school counselor, attendance worker, nurse, social worker, speech correctionist, remedial reading teacher, librarian, physical education teacher or coach, the school or family physician and psychiatrist—whoever is or should be playing a role in the child's school life—must be involved. The psychologist plans each conference so that it will not only benefit the child, but contribute to the growing insight of all concerned, including himself.

Work with community agencies

Many of the problems clarified by a case study cannot be solved either by the school or the home. Other community agencies (clinics, courts, recreation agencies, employment and rehabilitation agencies, police and probation agencies, foster home and family welfare agencies, churches, and others) must be brought to bear on a particular case. Whether the psychologist is the one to make such contacts, or whether this is a responsibility of administrators or other pupil personnel specialists depends on local circumstances. The responsibility for referral should be thoughtfully worked out and latitude for exceptions should be generally understood.

Written reports

Though the bulk of the communication about a child should be verbal and preferably face-to-face, written reports and records of a psychologist's work are essential to any professional program. In the psychologist's confidential file

should be kept the details of test findings, the specifics of health and social history, and the information given confidentially by pupil, parent, or other person, with dates attached in all cases. Summaries of findings and recommendations should be stored in pupil folders and made accessible to all school personnel. Usually, several copies to various teachers and other staff members are required. Every school psychological service needs adequate clerical assistance to keep records, maintain accurate files, and transcribe dictated reports.

BROADER ASPECTS OF A SCHOOL PSYCHOLOGIST'S FUNCTION

Heretofore, we have been describing the role of the school psychologist as a clinician. The small number of children who can be served in the depth described, and the advances in psychology that are of consequence to the school as a whole, lead to a search for ways to make broader use of the psychologist on the school staff. All of the functions described below are currently carried on in many schools; probably all school psychologists are involved occasionally in at least one or more, and some psychologists may be predominantly or entirely utilized in these ways. Increasing attention is being given to many of these areas, as statewide plans and policies for utilization of psychologists are developed, as training programs are set up, and as the actual and potential contributions of the psychologist to the school program are assessed by national groups.

Inservice education of teachers

Informal contributions of the psychologist to the personal and professional growth of teachers have been mentioned in reference to the case study. To the extent that administrators and teachers find him useful, the psychologist is likely to be called upon for more formal participation in staff development programs.

Parent education

The effective school psychologist receives many requests to speak to parent groups, and he may meet with small groups to explore a subject in depth. He expects to give many afternoon and evening hours to this work, in order to help interpret the school as a whole and the psychological services in particular to the community.

Consultation on school committees and special projects

Curriculum committees may call upon the psychologist for advice on how and where in the curriculum to introduce units in self-understanding, mental health, or human relations. The psychologist may contribute to plans for early admission, multiple track programs, remedial reading, extended school days, recreational needs of teenagers, and programs for pregnant girls, the brain injured, or youth returning from custodial institutions. All these problems of instruction and administration have psychological implications.

Group testing programs

Most schools today have extensive programs of group testing, frequently for intelligence and achievement and less frequently for other aptitudes and interests. The school psychologist often serves as a consultant as schools continually reevaluate their tests; forms of reporting; methods of interpretation to teachers, pupils, and parents; and precautions taken, especially if such tools are used as part of a process of classifying pupils.

Community relations

An alert psychologist with skill and training in communications and social psychology may be helpful in the public relations program of the school. He may help to interpret school policy and problems, or to establish a receptive attitude toward bond issues or tax increases. He may help to plan campaigns or public relations materials if his abilities lie in this direction.

Research

A great body of behavioral science knowledge could be applied in American schools. Problems of learning, motivation, social organization, group structure, mental health, and optimum human functioning have been fields of active inquiry by research psychologists. The school psychologist has an important role as an interpreter of the results of such research.

As more staff time is allotted to research, the psychologist is frequently one of the first persons to be involved. He is sometimes among the best trained staff members with respect to designing, carrying out, and evaluating research proposals because research has high priority in all university training programs in psychology.

TRAINING AND CERTIFICATION

Training

The person qualified to carry on even the minimum functions just outlined obviously must have extensive graduate training in both psychology and education. He needs a solid foundation in psychology as a science—general, experimental, theoretical, physiological, comparative, statistical, and research. He needs clinical tools for the diagnosis and treatment of children, including counseling, play and group therapy, and an approach to psychotherapy. He should have a broad base in learning theory and the psychology of motivation. He needs much understanding of child development, adolescent psychology, human relations, psychology of groups, juvenile delinquency, mental retardation, social psychology, personality theory, and abnormal psychology.

In education, he needs a basic understanding of the history, philosophy, organization, and administration of the American school system, tests and measures as used in schools, classroom management, school guidance programs, remedial instruction, special education of exceptional children, and perhaps most of all, an appreciation of the presently mounting pressures on schools. When we consider that he must also be a broadly educated human being with all the help the humanities and sciences can give toward developing a rounded personality, and be sensitive to his responsibilities to himself, his family, his community, his nation and the world, the training task may well appear impossible.

Each of the areas of psychology and education listed above could well be the topic not merely of one course but of a sequence of courses. The student attempting to undertake all of them would have a long gray beard before being ready to begin his professional career. Fortunately, training programs specifically geared to school psychology are being developed to provide the essential content from most of these fields in a coherent program with a minimum of overlapping. It is not surprising that official statements on the topic by committees of psychologists universally recommend a doctoral program for a fully qualified school psychologist, including a carefully structured internship following practicums in connection with clinical courses. There is, however, general recognition not only of the unreality of this requirement in view of numerical needs and salaries available in schools, but also of the feasibility and desirability of using persons of different levels of training for the varied functions into which the psychological program may be divided.

Certification

Today most persons employed as school psychologists must meet training and experience standards determined by various State departments of education. In 1960, 23 States and the District of Columbia, in which substantial numbers of school psychologists were employed, had some form of certification requirement for school psychologists.[2]

It is probable that additional States have since instituted certification standards. Hodges found the master's degree (or equivalent) universally required, and 2 graduate years commonly mentioned. The four States that specified a doctoral degree for the "school psychologist" also had certification standards for lower level psychological workers with different titles. In 1960, 14 States specified either teacher certification or eligibility for teacher certification as part of the requirement. There appears to be a trend to replace this requirement with an internship in a school setting, accompanied by specific training in understanding school problems.

The American Psychological Association now recommends full certification at the doctoral level, provisional certification with 2 academic years in graduate courses, and certification as a "psychological assistant" with 1½ academic years of graduate training to work only under supervision of a certified school psychologist.[3]

[2] Hodges, Walter L. "State Certification of School Psychologists," *American Psychologist*, 1960, vol. 15, pp. 346–349.

[3] Bardon, Jack I., and the Division 16 Committee on Training Standards and Certification. *American Psychologist*, vol. 18, 1963, pp. 711–714.

New Emphasis on Role and Training for the School Psychologist

By ELI M. BOWER, Consultant, Mental Health in Education, National Institute of Mental Health

THE EFFECTIVENESS of the school as a primary institution lies in its ability to maintain degrees of elasticity and flexibility by which it can provide educational services to all children. When it is unable to do this, large numbers of children are unsuccessful in the cognitive affective tasks required by the school, and a public mental health problem results. Therefore, the school psychologist needs to apply his behavioral science skills to the basic rigidities and organization of the school system, in addition to helping the casualties and extrusions from the system. He should be preventing school casualties rather than merely treating them. As a behavioral scientist, he must find methods of utilizing his experience and insight to grapple with the problems of children who fail to learn, in such ways as to insure the success of the school system with other children who show comparable learning behavior problems.

To achieve the purpose of "prevention," a graduate program for training school psychologists would have to be specially designed. The program might be headed by a "master" behavioral scientist with a part-time staff composed of a public health psychiatrist, clinical psychologist, anthropologist, school administrator, social worker, and remedial educational specialist. All candidates in the 2- or 3-year program would be placed immediately in schools as half-day workers with children and adolescents as teacher aides, as school administrator *alter egos*, and in all cases, as behavioral science students in the school. The experiences of these students in the school would be integrated and expanded by a flexible academic seminar of not more than eight students, with the initial emphasis placed on personality (including cognitive) development and dynamics.

A full year would be given to acquiring:

1. A usable and operable professional self, one which is free to take in and process data and correct self and other perceptions;
2. A usable and understandable theory of personality development and dynamics; and
3. Clues and hypotheses about the school social system, school curriculum, and procedures which might be used to build ego strength of children through cognitive-affective transactions in the school.

The first part of the academic program would be faculty centered, but would involve the students more and more in presentations and analyses growing out of their work situations. Where areas of puzzlement or omission were perceived by staff, an appropriate presentation would be planned and given. If, for example, the problem of teaching reading to slow students became a concern of the group, it could be explored by interested members of the staff. For those students who evidenced more than a cursory interest, the topic could be explored in depth. In all of these and other sparkings between the school-centered experiences and the college staff, the emphasis would be on making the student a learner about self—about self in relation to the school as a system—and a learner of how children and adults can be helped to function best in the system. Above all, the student would seek to find ways of helping the school build ego strength in children as well as repairing deficiencies which curtail effective learning. Individual studies of healthy as well as disordered children would focus primarily on the use of curricula as foundations from which teachers could stimulate human growth.

During the summer the eight students would operate their own school for selected students. The curriculum might include remedial instruction, work with parents, learning how to apply psychological information about children to specific educational procedures, and how to use standardized interviewing techniques including tests.

In the second year the emphasis would be placed on:

1. Interpersonal skills such as interviewing, testing, communicating findings of teachers, counseling parents, and working with other pupil personnel workers; and
2. Research skills and measurement techniques.

Both of these areas of study would be carried out in the school in small laboratory or simulated settings from which problems could be presented to students and staff. The focus

of this work for the school psychologist would be on assisting other school staff in learning how to use him as a consultant and professional resource in the behavioral sciences.

The program during the last or third year might include research design, basic experiences with exceptional children in community settings, and social psychology and sociology of organizations and social change.

The product of such a program would be a behavioral scientist or school psychologist whose expertise and training have been school centered. Such a person not only would assist the teacher with individual students, but also would enhance educational transactions in that class in a positive program of prevention. In addition, he would assist other pupil personnel workers, administrators, and curriculum staff to understand and use behavioral science know-how and knowledge to carry out their own duties.

Currently, a public school system is fortunate if it has even one school psychiatrist. Consequently, the greatest number of students may be benefited by a program of prevention through psychiatric consultation with the school staff. With the slow but inevitable increase in numbers of child psychiatrists and other mental health workers in schools, direct therapy for disturbed children may eventually be provided.

PART II—CHAPTER 5

PSYCHIATRIC SERVICES

By WILLIAM G. HOLLISTER, M.D., Professor of Community Psychiatry, Department of Psychiatry, University of North Carolina Medical School

The opportunity to serve as consultant to school systems provides the psychiatrist with some fascinating challenges in applying his art and science. Since approximately 7 to 14 percent of children attending school each year have some sort of emotional, behavioral, or psychosomatic problem, or learning problem of psychological origin, school personnel are confronted with the task of dealing with them. Most of these children have mild, minor, or transitory problems arising from developmental or situational causes. A lesser number have moderately severe problems of the general nature that are usually seen in child guidance clinics. A seriously ill child is rarely encountered in school.

Since American tradition places our schools under local school boards and each system is quite different in organization and program, it is impossible to make generalizations that would fit all school systems. Some local school jurisdictions completely ignore the existence of mental health problems in their children and consider their mission quite separate from mental health, least of all psychiatry. On the other hand, there are school systems which are highly sensitive to the mental health and social problems of their pupils and consider their solution or amelioration closely related to the task of educating a useful member of society. Some of the largest psychiatric child guidance clinics in the country are now operated under school board auspices. The fact that a large number of schools have child study units, psychological clinics, school social casework, special classes, guidance counseling, and mental health units in their school health programs attests to the growing acceptance of the principle that schools must deal with the "whole child" and

that an attempt should be made to give every child an education that befits his individual potential, even if he is handicapped by mental retardation or emotional illness. In their ultimate goals, education and mental health both seek the maximum development of the potential of each individual.

THE SCHOOL SYSTEM'S NEED FOR A PSYCHIATRIC CONSULTANT

Almost any school system, especially one serving 5,000 or more children, encounters a number of behavioral, emotional, and psychosomatic problems in its students and staff as part of its daily operations. Successful resolution of these problems permits more student and staff energies to be devoted to the work of learning. In addition to helping its people resolve problems that interfere with the educational process, the school has two other major mental health responsibilities—the prevention of behavior and emotional disorders stemming from the school situation, and the positive task of building personalities (promoting ego strengths) capable of effective learning and application of knowledge. In fulfilling these three mental health related obligations, a school system frequently turns to behavioral scientists, including a psychiatric consultant.

Where are behavioral understandings most crucially being applied through consultation in a school system? Where do psychiatrists find an opportunity to contribute their skills? A quick overview of the average complete school program will pinpoint the following possible areas of work for a psychiatric consultant: school health program; pupil personnel department; special education programs (for the emotionally and physically handicapped and the retarded, etc.); child study unit; research section; teacher health program; classroom-behavior management; and consultation with the school administration on problems of personnel management, staff relations, and policy development. In each of these settings psychiatrists can and do contribute.

School health program

Here the psychiatrist's clinical knowledge can help general physicians and nurses assess the many tension and stress problems they see daily. School is one of life's major challenges—a "must" beset with pressures, demands, expectations, and failures. These problems come to the school health unit hidden behind stomachaches, headaches, fatigue reactions, nervous symptoms, and frank anxiety attacks. Most

school principals and nurses are not equipped to manage some of these problems and will gratefully use the counsel, training, emotional support, help in planning, and referral resources a psychiatric consultant can provide. This is mainly clinical consultation.

Pupil personnel department

In most school systems the largest concentration of mental health trained personnel is placed in this unit. The responsibilities, functions, and the numbers of psychologists, social workers, attendance workers, guidance counselors, remedial therapists, speech clinicians, and others vary widely from system to system. Some school boards hire only one kind of pupil personnel worker, while a few have developed collaborative teams of these specialists with certain roles in common, as well as unique role functions. A psychiatric consultant asked to serve such specialists must carefully diagnose their operational patterns, as actual roles may vary widely from stereotyped concepts of each discipline's function—often beneficially. Since professions may have various grades of specialists (certified, masters degree, and doctoral levels), and since natural capacity to relate to parents, teachers, and children often exists without relation to level or type of training, the roles assigned and accepted may show marked variation from the usual hospital and clinical functions of these same disciplines. Whatever roles they may perform, members of the pupil personnel staff all encounter difficult problems of assessment, diagnosis, interpretation, and interpersonal relations, and many of them welcome problem-centered consultation from a psychiatrist who is capable of translating his clinical understandings, derived from studies of the severely ill, into pragmatic help in dealing with these children who have minor problems.

Special education programs

Although various school boards organize them differently, most school programs provide a number of *special* education opportunities. These include provisions for tutoring, remedial reading, speech therapy, resource rooms, special classes, special schools, hospital or homebound teaching, as well as camps, special summer programs, or reduced time programs for children with varied mental or physical disabilities. The staff operating these programs not only has to deal with the emotional and social aspects of physical handicaps, but also provide special educational experiences for trainable retarded, educable retarded, and emotionally handicapped children. The children are frequently grouped into helping classes of 16 to 20 pupils or special classes of

4 to 10, or are managed in a regular class with special assistance to the teacher. In addition, the school frequently has individual and group contacts with the parents of these children where family interactions and attitudes must be managed wisely if results are to be realized in school.

Frequently, the school staff members in each of these special education programs are confronted with quite difficult decisions and problems regarding screening, diagnosis, proper placement and grouping of students, routine assessments, evaluation of program, and the task of interpretation to parents or other staff. These are prime areas for psychiatric consultation.

Child study unit

Most of the larger school systems have developed centralized units to conduct psychological studies in depth. These operate under such names as child study unit, psychoeducational clinic, child guidance service, or clinic. In these settings the psychiatrist usually functions as a member of an interdisciplinary team. In the more fully developed units, the psychiatrist is asked to provide diagnosis, treatment, supervision, staff training, consultation, and planning functions similar to those performed by a psychiatrist in a child guidance clinic.

Research section

Less frequently, but increasingly over the last few years, school systems, university laboratories, or demonstration schools have developed research programs utilizing psychiatric participation and consultation. Psychiatrists working in these settings may serve as assessors of the change of certain dependent variables, observers and interpreters of various dynamic processes, and occasionally, as part of the intervention. Those with research experience often share in the preparation of design and sample selection, as well as in tool validation and reliability testing phases of the research.

Teacher health program

Certain school systems utilize some of the psychiatric services available to them to provide clinical services to their staffs, not only as a part of the personnel services of the organization but also as an additional safeguard of the general mental health of classroom groups. Entrance examinations, on-the-job appraisals, selection for promotion and leadership, checking suitability for duty, and providing assistance to individuals, are some of the services requested of the psychiatrist. Some sophisticated systems make available to their staff—in anonymity—a panel of psychiatric consultants as part of an employee health service. This

health benefit is sometimes covered by insurance and functions as in private practice.

THE PSYCHIATRIST AS CONSULTANT TO THE TEACHER

The work of the psychiatrist as consultant to the teacher has been selected for separate emphasis because specific modes of functioning in this area have recently received more complete delineation in the literature.[1] The National Institute of Mental Health cosponsored two conferences on this problem with State mental health authorities of Pennsylvania and with mental health specialists of California.

To become really practical for the teacher, successful consultation must move beyond describing the child's needs and the meanings of his behavior into the realm of helping the teacher with his hour-by-hour classroom management. Even children under therapy or casework management still come to school and must be dealt with constructively in the classroom.

Most important is the consideration that the recommendation to the teacher must be translated into and communicated in his language.

The psychiatrist must acquire the standard behavior management terminology of the classroom teacher in order to communicate effectively with the teacher.

Since consultation in any nonpsychiatric setting requires that the consultant first study the setting thoroughly, he can ask for an orientation experience before he begins work. By observing classes in order to list and categorize types of behavior management techniques used by teachers, he can soon build up an image of what teachers can and cannot do. He may observe a teacher's emotional climate-setting meth-

[1] Caplan, Gerald, ed. *Prevention of Mental Disorders in Children.* New York, Basic Books, 1961.

———. *Mental Health Consultation.* New York, Grune and Stratton, 1962.

———. "Mental Health Consultation in Schools." *The Elements of a Community Mental Health Program.* New York, Milbank Memorial Fund, 1956.

Klein, Donald C., and Lindemann, Erich. "Preventive Intervention in Individual and Family Crisis Situations," chapter XIII, p. 283–306. *Prevention of Mental Disorders in Children.* New York, Basic Books, 1961.

Lindemann, Erich. "The Wellesley Project for the Study of Certain Problems in Community Mental Health," p. 167–185. *Interrelations Between the Social Environment and Psychiatric Disorders.* New York, Milbank Memorial Fund, 1953.

ods, his use of anticipatory guidance, his methods of social management, and his redirection of poor behavior, as well as various ways a teacher meets children's emotional needs indirectly through activities with peers and through direct emotional support.

Psychiatrists engaged in teacher consultation frequently are called upon to serve as group consultants. Some have found it wise to use a completed case as a springboard for discussing the children who are not yet cases but who are showing early signs—the precases. Such discussions often move into the topic of preventive management so that these children do not become candidates for individual help. In summary, work with teachers provides opportunities to sharpen their sensitivities and strengthen their role as teachers and can become an effective method of primary prevention.

THE PSYCHIATRIST AS CONSULTANT TO THE SCHOOL ADMINISTRATOR

This consultant role is selected for fuller exposition because of its importance and special technical considerations. Considering his high status and extensive training, it might be expected that the psychiatrist would quickly be accepted into the inner office of the superintendent to give counsel on those matters of policy and practice that would affect the emotional well-being of all school children. Observations in the field indicate that this rarely happens as the opening gambit. Instead, this high opportunity seems to come step by step through a process of role evolution.

Problems of role evolution

A psychiatrist coming to work in a school system usually meets with initial hospitality and high expectations. Later disappointment reactions may appear as his limits become apparent. Frequently he is first perceived as an omnipotent clinician and will receive referrals of the most severe problem cases that have accumulated in the system over the years. Many of the first referrals will be total transfers of responsibility (dumping) as the schools seek to rid themselves of problems and unload them on the new specialist. The predictable occurrence of this phenomenon is indication that this problem should be anticipated and should be carefully discussed with the administration ahead of time. Such problems may be minimized by a careful explanation to the staff of the psychiatrist's role.

As stereotyped concepts give way to reality, a phase of "testing" often appears. Through difficult referrals and other

devices, the school staff tests the skills of the psychiatrist. As the psychiatrist passes these "tests" and demonstrates that *he can identify with the educators' mission*, new opportunities are opened up to him.

From consultant in clinical matters regarding pupils and staff, he may be asked to counsel with parents, or consult with teachers on general classroom behavior management. He may move on to sharing in the inservice training of teachers or pupil personnel staff, participating in a study group, and working on a curriculum committee. As he becomes "safer" and more closely identified with educators, the psychiatrist may be requested by the principal, or some central staff person, to work with him. As these extensions of trust are fulfilled, the psychiatrist may be invited to become a direct consultant to the central staff and the superintendent. This sequence of roles and processes has been called "the role evolution process." Recognition of the needs and dynamics that create this phenomenon will help the psychiatric consultant expedite this process.

A psychiatrist who eventually serves the principal or superintendent as a more or less personal consultant will frequently be asked to give counsel on difficult staff relationship problems, or asked to suggest ways to understand and cope with fanatics, professional critics, or with parents who harass the faculty. These clinically related needs are usually augmented by the school administrator's desire to understand his own role and feelings as he tries to cope with the stresses of his job.

After the psychiatrist-administrator relationship has matured into considerable trust, the consultant may be presented with bids to help and advise on school system or communitywide social psychiatry problems. Information and guidance may be requested on ways to build staff morale, or ways to redirect parent and citizen hostilities and fears into constructive support. The psychiatrist may be asked to examine school policies to help in setting up "exception mechanisms" to avoid harmful impact on certain individuals. At this stage the consultant may find himself far from his usual clinical base and in need of considerable scholarly review of the social psychological research on administrative process. Even in these matters of policy, it is essential to provide the understanding of personality dynamics and interpersonal processes in order to humanize educational policy. Thus, psychiatrists have a service to offer at all levels of the school system—from pupil to superintendent of schools.

A child with a communication disorder may be handicapped in school and in his personal development. Without assistance, he will have one strike against him when, as an adult, he seeks to establish himself in the working and social world.

PART II—CHAPTER 6

SPEECH AND HEARING SERVICES

By PARLEY W. NEWMAN, Associate Secretary, American Speech and Hearing Association

The primary purpose of speech and hearing services is the remediation of disorders of human communication. The term "communication disorder" means an impairment in speech, hearing, or language, or some combination of these.

The consequences of serious disabilities of communication are far reaching. A disorder of communication may inhibit an individual's social adjustment, restrict his economic potential, and reduce his learning ability. Normal speech development is even essential to the normal maturation of thought processes.

The profession which has concerned itself with disorders of communication is new and growing rapidly. An indication of its recent emergence is that, at the present time, several different names are attached to it. However, speech and hearing profession is the title most commonly used. The specialist who is concerned primarily with speech disorders is known as a speech pathologist, speech clinician, speech correctionist, and speech therapist. The person who is primarily concerned with disorders of hearing is called an audiologist.

Many school systems throughout the country have established speech and hearing programs to alleviate the problems in learning created by disorders of communication. A description of the ideal program is impossible, for local conditions vary and new methods remain to be tested. Nevertheless, some suggestions are provided here for the consideration of school officials who may need information now while waiting for more definitive results from research such as is currently being conducted by the Interprofessional Research Commission on Pupil Personnel Services.

INCIDENCE AND PREVALENCE OF SPEECH AND HEARING DISORDERS

Within the total population of handicapped children in the United States, the largest subgroup consists of children with speech and hearing problems. More than 3 million children have speech or hearing so seriously impaired that it interferes with their educational, social, or emotional adjustment. An estimate made in 1959 [1] indicates that 5 percent of our school-age children have speech problems.

If we take a typical city with a population of 40,000, and assume a school population of approximately 10,000, we would expect to find 500 children with speech handicaps. Table 1 represents the estimated number of these 500 school children with each type of speech problem.

Table 1.—Estimated number of school-age children in a school population of 10,000, with each type of speech problem

	Number of children with speech problems
Articulation problem	300
Stuttering	100
Voice disorder	10
Speech problems due to cleft palate	10
Speech problems due to cerebral palsy	10
Retarded speech development	20
Speech problem due to impaired hearing	50
Total	500

The above estimates are believed to be conservative and, in some instances, may underestimate the magnitude of the problem. An additional 0.7 percent of school-age children have hearing losses which are significantly handicapping. Another million school children have nonhandicapping reductions in hearing acuity.

TYPES OF COMMUNICATION DISORDERS

The types of speech disorders usually found in elementary and secondary schools are briefly defined.

[1] Liaison Subcommittee on Legislation, American Speech and Hearing Association, "The Need for Adequately Trained Speech Pathologists and Audiologists." *ASHA—A Journal of the American Speech and Hearing Association*, vol. 1, No. 4, December 1959, pp. 138–139.

Articulation disorder

The child with a problem of articulation has difficulty in producing the sounds of speech. The extent of disability covers the entire range of severity, from misarticulating one sound to completely unintelligible speech. As shown in table 1, the problem of misarticulation is the most common type of speech disorder.

Speech problems due to cerebral palsy

The neuromuscular disorder of cerebral palsy is manifested in several ways and usually results in speech and language impairment. A child with cerebral palsy may have motor, sensory, and perceptual disturbances which make it difficult, if not impossible, for him to speak and utilize the symbols of language.

Speech problems due to cleft palate

The speech of a child with a cleft palate is generally characterized by poor articulation and nasality, and is often very difficult to understand. The child with a cleft palate is born with an opening in the roof of the mouth. This opening makes it impossible or difficult to produce normal speech sounds, for nasal resonance and nasal escape of sound interfere. It is extremely unlikely that a child with cleft palate speech would reach school age without having undergone surgery and perhaps prosthodontic treatment to correct the birth defect. Yet, in many cases, these children need assistance in acquiring appropriate speech.

Speech problems due to impaired hearing

Unlike the deaf child, the hard-of-hearing child is found in regular classrooms. He is not deaf but experiences difficulty in sound reception. The degree and types of hearing impairment vary widely, and thus, require expert assessment and interpretation. If a child has difficulty in hearing certain sounds of speech, he will probably be unable to pronounce them correctly.

Speech problems due to stuttering

The tense, repetitious, or hesitant speech of some children is quickly evaluated by most persons as stuttering, but the problem is more complex than the overt manifestations might suggest. The child who stutters should receive help as soon as possible to reduce the possibility of the problem becoming firmly entrenched.

Voice problems

A serious deviation in voice production can significantly interfere with the normal process of communication. It may also indicate an organic problem needing medical treatment.

Speech problems due to delayed speech development

Delayed speech or speech retardation does not indicate a specific kind of disability, but is a broad term covering a multitude of problems in which, for one reason or another, a child does not learn to talk or talks minimally. The causes for the delay in the acquisition of normal speech and language may be environmental or organic, or both.

Speech problems due to aphasia

Aphasia is a language disturbance resulting from damage to certain areas of the brain and is manifested in many ways. In general, the person with aphasia has difficulty in using the symbols of language. Difficulty with symbolization may create problems in speaking, writing, reading, listening, and arithmetic.

Speech problems due to mental retardation

The child who is mentally retarded often has speech and language problems. Improvement in these skills may result in increased learning potential.

Speech problems due to bi-lingualism

A child who is exposed to two languages during the years his speech is developing may learn both languages, but this distinct dual stimulation may be detrimental. This child's speech and language may be found lacking when compared with his peers who have been exposed to only one language.

THE SPEECH AND HEARING SPECIALIST [2]

The communication processes are very complex forms of human behavior. Therefore, a substantial amount of training is required to achieve the competence necessary to correct disorders of communication. The great demand for individuals to serve speech and hearing handicapped children has resulted in many persons being employed who are minimally, if not inadequately, prepared.

[2] Executive Council, American Speech and Hearing Association. "Services and Functions of Speech and Hearing Specialists in Public Schools." *ASHA—A Journal of the American Speech and Hearing Association*, vol. 4, No. 4, April 1962, pp. 99–100.

Research Committee, American Speech and Hearing Association. "Public School Speech and Hearing Services." *Journal of Speech and Hearing Disorders*," monograph supplement No. 8, June 1961.

Typically, the person who is trained to a level of competency in speech and hearing has at least a masters degree. He can present evidence of the completion of perhaps 60 semester hours constituting a well integrated program in courses that provide: (a) background information needed to understand the processes of speech, hearing, and language; (b) fundamental information relative to the management of communication disorders; and (c) information supplementary to these fields. Subject matter areas fundamental to the training of speech and hearing specialists include: human development, anatomy, physiology, psychology, and physics.

Specialty areas studied by the student majoring in speech pathology and audiology include: (a) current principles, procedures, techniques, and instrumentation used in evaluating the disorders of speech, language, and hearing; (b) classifications, causes, and manifestations of disorders of speech, language, and hearing; and (c) principles and remedial procedures used in habilitation and rehabilitation of those having various disorders of communication.

The training of the competent clinician also includes supervised clinical practice consisting of several hundred hours of actual diagnostic and therapeutic experience with communicatively impaired individuals under the guidance of competent professionals.

CASELOAD

The services of the speech and hearing specialist can best be utilized if they are directed toward children having significantly handicapping speech, language, and hearing problems. Such work is often individualized and time consuming. A child with a significant communication handicap should be seen at least twice a week for 20 to 25 minutes. It is possible that a total of 12 children would require the full-time services of the speech clinician.

Sometimes the number of children served can be increased by grouping together three to five children who have handicaps in common. If small groups are utilized, it is conceivable that an efficient clinician could work with as many as 100 children a week. Because of the diversity of problems that a clinician meets, however, it would be unreasonable to expect that all work be done in groups. If some work is performed with individuals and some with groups, the caseload will be more than 12 and less than 100.

The teacher, clinician roles

A clarification of the role of the speech and hearing spe-

cialist in the public school is pertinent. This specialist provides evaluative (diagnostic) and habilitative (therapeutic) services for individuals handicapped by impairments of language, speech, or hearing. His services must be integrated into the general goal of the school although his specific responsibilities, skills, and basic professional identity are those of the clinical worker in speech and hearing. The educational requirements necessary for clinical competence and the nature of the services provided do not vary in any fundamental way for the employment of clinicians in different settings (hospitals, clinics, schools).

Even though he works in the elementary and secondary schools, the functions of the speech and hearing specialist are different from those of classroom teachers, including teachers of the deaf, teachers of the mentally retarded, and teachers of general speech or speech improvement. Teachers are importantly concerned with instruction in subject matter and teaching certain skills as determined by the curriculum of the school. They must have the educational preparation which provides them with the knowledge and techniques for such instruction. On the other hand, as has been indicated, the work of the speech and hearing specialist is in the nature of evaluative and habilitative service which is related primarily to the communication handicaps of an individual. The educational preparation of this specialist must equip him to carry out a clinical service program which does not involve the teaching of curriculum materials. To require the student majoring in speech and hearing to take all the course work required of the educational major or the special education major would be inconsistent with the nature of the profession and would interfere with the achievements of the primary goals of the speech and hearing programs in the schools.

Adequate clinical services require time for diagnostic evaluation, planning of individual therapeutic programs, individualized clinical and remedial services, satisfactory record-keeping, and the necessary counseling of parents and others. There are, however, many instances where speech and hearing specialists are required to serve children in numbers which preclude individual attention. Too often, the number of children seen, rather than the quality of service rendered, is the criterion for program evaluation.

SPEECH IMPROVEMENT AND SPEECH ARTS

In addition to speech habilitation, there are at least two other areas of speech activity found within school systems—

speech improvement and speech arts. In order to administer a program of speech and hearing services effectively, the administrator must understand how these activities differ from speech habilitation.

Speech Improvement

All children can profit from activities which increase their speech and language skills. A heightened awareness of individual speech sounds facilitates the mastery of reading, spelling, and speaking skills. Many activities have been developed to help the child recognize individual speech sounds, discriminate among them, and apply these perceptions in the overall language program. These speech improvement activities properly belong in the classroom and can be effectively taught by the classroom teacher with the advice and counsel of the speech and hearing clinician.

Speech arts

Beyond the speech improvement activities are the speech arts which appropriately can be taught by the classroom teacher or specialist. The contributions of the speech arts teacher are in the areas of public address, oral interpretation, dramatics, and the other aesthetic activities associated with speech.

INTEGRATED PROGRAM

A disorder of communication has many facets. As a result, the contributions of many professionals may be sought. Oftentimes there are organic components in the etiology which require the services of the nurse and physician. Inasmuch as speech and language processes are a part of total behavior, the school psychologist has an important contribution to make. Furthermore, since the communication disorder has part of its roots in the home, the school social worker can contribute much to rounding out the picture of the child's home environment which is fundamental to an understanding of the speech and language problem. Thus, a full program integrating the services of several professions is most desirable in helping to alleviate the problems associated with disorders of communication.

The speech clinician who works with a child must understand what the teacher is trying to accomplish in the classroom so the habilitation aspects can be related to and integrated with the classroom program. The child will never master new patterns of speech and language until he can begin to apply them in real situations, and the classroom is one of the most important places where new behavior can become habitual.

The administrator directly in charge of the pupil personnel services should work to create opportunities whereby interprofessional exchange not only takes place but is facilitated and encouraged. The phrase "teamwork" is often used, but is often abused. A pile of reports from the physician, the psychologist, the speech clinician, etc., does not represent teamwork unless these individuals sit down together from time to time, exchange ideas and come to a concensus regarding the management of individual problems of pupils.

IDENTIFICATION

How are the children selected to receive services? One method is teacher referral. Another approach is the screening of all children by speech and hearing personnel.

The teacher referral method has some disadvantages. A teacher may be unaware, sometimes, of certain problems in children which are in need of remediation. For example, a child may be inattentive and seemingly uncooperative in the classroom. It may not occur to the teacher that this behavior could be the result of a partial hearing loss. Another teacher may think that calling attention to a speech problem by selecting a child to receive special treatment would be more detrimental than not referring the child for help. This reasoning is not supportable by actual experience. Not referring him for assistance amounts to neglect of one of his most basic needs.

Speech screening

A screening technique whereby speech and hearing personnel listen to brief samples of each child's speech is perhaps the most effective technique for identifying children with speech problems. This should be accomplished at the beginning of the school year.

To speed up the screening, assistance may be solicited from students majoring in speech pathology and audiology at neighboring universities or colleges. When this semiprofessional help is used, 10 students can assist in the initial screening of as many as 1,800 children in a single day. This is a valuable experience for students and assistance of this type can often be obtained.

Hearing screening

Screening for hearing loss is often termed *identification audiometry* and requires the use of an instrument called an

audiometer.[5] Ideally, it would be desirable to test the hearing of every child every year, but compromises are often made due to expenses involved.

In newly established programs, however, an effort should be made to test all of the children during the first school year. Thereafter, an adequate program includes annual testing in kindergarten and grades 1, 2, and 3, and less frequent testing in grades 3 through 12. More important than scheduling hearing tests in certain grades every year is to make sure that no child fails to have his hearing tested at least every 2 or 3 years.

An adequate program should include opportunity for immediate testing of pupils: (1) who are new to the school, (2) who were discovered by previous tests to have hearing impairment, (3) who have delayed or defective speech, (4) who are returning to school after a serious illness, (5) who are enrolled in adjustment or remedial classroom programs, (6) who appear to be retarded, (7) who are having emotional or behavioral problems, and (8) who are referred by the classroom teacher for hearing testing.

[5] Committee on Identification Audiometry of the American Speech and Hearing Association. "Identification Audiometry: Definition, Objectives, and Program Responsibility." The *Journal of Speech and Hearing Disorders*, monograph supplement No. 9, 1961.

School nursing was one of the first pupil personnel services. Its parent profession, nursing, pioneered in expanding health services by training practical nurses and nurse's aides. Likewise, school nursing may serve as the prototype for expanding other pupil personnel services through the selection and training of subprofessional personnel.

PART II—CHAPTER 7

NURSING SERVICES

By Pauline R. Carroll, Director of Health Services, School District of Abington Township, Abington, Pa.

Ostensibly, school nursing in this country was founded in 1902, when Lillian Wald assigned Lina Rogers as the first public health nurse to serve children in New York City schools.[1] In 1903, Miss Wald led a crusade to establish a Federal Children's Bureau which was realized in 1912 under the leadership of President Theodore Roosevelt.[2] Florence Kelly, an ardent fighter against child labor, and Lavinia Dock, a leader in nursing, lent support to this effort. Over the years the Children's Bureau has greatly influenced health services for children and youth both in this country and abroad.

In 1952, there were 6,309 nurses employed by boards of education,[3] while today, there are more than 12,000 so employed.[4] An unknown number on the staffs of public health agencies are likewise engaged in school nursing.

Through the years, educators in nursing, specialists in maternal and child health, explorers in nursing research, and practitioners in nursing for children of school age have put forth provocative, practical, and lofty ideas and ideals about nursing for school children. In addition, physicians, educators, public health specialists and generalists, welfare workers, and members of other disciplines have proposed concepts concerning better health for children of school age.

[1] Struthers, Lina Rogers. *The School Nurse.* New York, G. P. Putnam's Sons, 1917.

[2] U.S. Department of Health, Education, and Welfare, Children's Bureau. Washington, D.C.: *Five Decades of Action for Children,* 1962. *Trends.* Bureau Publication No. 367 (Revised), 1960.

[3] Swanson, Marie. *School Nursing in the Community Program.* New York, the Macmillan Co., 1953.

[4] American Nurses Association, *Facts About Nursing,* New York, N.Y., 1962.

FUNCTIONS

The statement, "Functions and Qualifications for School Nurses," prepared by the American Nurses' Association in 1960, may serve as a guide for the present and a basis for evaluation of services in the future. It presents the view that program, functions, and staff should be built upon school-community needs. Health needs of children, community resources, education and preparation of the nurse, State and local health laws, numbers of schools to be served, and required travel should be criteria for making school nurse assignments.

Schools have employed and continue to employ nurses because of their unique contribution in evaluating the health of children and in assisting with the modification of educational programs so that children may benefit more fully. The degree to which the school nurse carries out these functions depends upon such factors as school policy, her own preparation and experience, pupil load, needs of particular pupils in the school, and the availability of other community services.

A nurse who is responsible for planning and implementing nursing activities in schools may have the title of administrator, director, supervisor, consultant, coordinator, or chief nurse. A nurse working alone assumes varying degrees of the functions of administration, coordination, and supervision.

In relation to the administration of a local school health program, the school nurse gives leadership and guidance in its development and maintenance, and assists in planning and carrying out the nursing activities. She assumes a leadership role in the identification of those pupils with health needs that interfere with effective learning, and teaches school staff and others to recognize and report health deviations. She participates in faculty and parents' meetings and serves on committees concerned with safety as well as emotional, mental, physical, and social health.

The school nurse gives first aid and emergency care and helps children develop improved attitudes toward health, acquire health knowledge, and assume personal responsibility for their own well-being. She provides counseling and guidance to pupils, parents, and school personnel directed toward eliminating or minimizing health problems of pupils. She cooperates with other pupil personnel specialists when referral of children is indicated.

The nurse conducts studies in school health using available resources, and evaluates her program periodically in an

effort to improve it. She reaches out to the community and provides leadership in the coordination of the school program with the total health program, working with professional associations, civic groups, and community agencies.

PREPARATION

Proponents of school nursing and leaders in education have long promoted specific educational preparation for school nurses. The 1920's recorded concentrated efforts in California, New York, Indiana, and Pennsylvania, followed by New Jersey and Illinois, to secure and upgrade certification requirements for school nurses.[5] Approximately 30 States have followed this movement and many have secured regulatory provisions for the practice of school nursing.

Educators in nursing have endeavored to help, but they disagree with school practitioners who recommend that higher education should give specific training to school nurses at the undergraduate level. Western Reserve in Cleveland was one of the first universities to include undergraduate preparation for school nursing in a course for public health nursing.

[5] Troop, Eileen H. "Sixty Years of School Nurse Preparation." *Nursing Outlook*, American Journal of Nursing Co., New York, May 1963.

Early and continuing controversy regarding specialized nursing in schools versus generalized public health nursing including administrative practices has long clouded the issue of better preparation for school nurses. Although the basic nursing curriculum in colleges and universities devotes a reasonable amount of time to public health nursing, it rarely includes field experience in school nursing for the interested practitioner. Such experience was recommended more than 30 years ago by Mary Ella Chayer.[6]

Many believe that a nurse with baccalaureate preparation is adequate in a school setting if she is supervised by a nurse who has specialized in school nursing at the graduate level. At the present time, about 39 percent of the more than 12,000 school nurses in the United States have a baccalaureate degree. Such preparation is the minimum for acquiring specific professional skills applicable to a school setting.

A publication by the profession, based on recent research, outlines areas of preparation and experience needed to carry out present functions in school nursing.[7] However, little

[6] Chayer, Mary Ella, *School Nursing. A Contribution to Health Education.* New York, G. P. Putnam's Sons, 1931.

[7] National League for Nursing. *The Preparation and the Roles of*

evidence is available to show that these recommendations are being implemented.

ISSUES

Nurse-pupil ratio

There has always been discussion of the optimum nurse-pupil ratio. Obviously, the question of a defined ratio cannot be answered without an an assessment of health needs of school age children in given school communities. Plans are being developed by the American Nurses' Association to cooperate with appropriate Federal agencies for research in this and other selected areas of school nursing which, it is hoped, may contribute to the effort of the Interprofessional Research Commission on Pupil Personnel Services.

Supervision

Supervision in nursing, as in teaching, has long been an accepted practice, yet it has been slow to develop for the school nurse group,[8] in spite of the profession's recommendations and continuing efforts. Very few States or localities provide this service and many school nurses work alone, far removed from nursing supervision.

Personnel policies

Personnel policies for school nurses are generally rewarding. In areas of the country where responsibility and preparation are comparable to that of other faculty members, the privileges and benefits are usually commensurate with those of other professional personnel. Actually, higher salaries were paid to school nurses than to teachers in the early days. It seems reasonable to assume that salaries for school nurses should be commensurate with their preparation and experience and the unique contribution that they make to the learning experience of children.

Nonprofessional workers

Over the years, little attention has been given to the use of ancillary personnel in schools. A study done by the writer in 1961–62 demonstrated that a nursing staff of 12 spent time in clerical and housekeeping duties equivalent to that

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Nurses in School Health Programs. Guidelines for the Use of Administrators, Educators, and Students. New York, The League, 1962.

[8] Murphy, Ethel T. "Nursing Supervision for School Nurses. What Does It Offer?" *American Journal of Nursing,* vol. 62, No. 1, January 1962.

of two full-time nurses.[9] This is not only expensive clerical help, but a serious waste of professional time. The employment of medical clerks can alleviate this problem.

Eileen H. Troop recommends experimentation with the services of a new type of nonprofessional personnel.[10] Such workers would free school nurses for professional work with certain groups of children, especially those with emotional problems and other handicaps which require concentrated followup. Careful selection, professional guidance, supervision, and clearly defined duties for nonprofessional personnel workers would be essential.

TRENDS

Throughout the country, there is a trend to organize divisions of pupil personnel services in State and local educational systems. Regardless of the employing agencies, nurses and physicians are the health specialists in these services and should assume their places as members of the pupil personnel service team.

One trend in State departments of health is the employment of consultants in maternal and child health who are skilled in school health practice. There is no evidence that this trend exists in State departments of education, although there are valid reasons for school nursing to have leadership from this department.

School health services are increasingly being expanded along with other health and welfare services through programs provided by National, State, and local agencies. The growing concern for the health of children is reflected in large Federal appropriations designated for this purpose.

In need of research

Areas of research which may well be integrated with the program of IRCOPPS include the following:

1. The unique contributions of school nursing.
2. The school nurse's responsibilities in maternal, infant, and preschool health to prepare children to enter school.
3. The level of education needed by school nurses.
4. Certification requirements for school nurses.
5. Relative effectiveness of various patterns of administration in school nursing.
6. The use of nonprofessionals to assist school nurses.

[9] Carroll, Pauline R. *A Time Analysis of School Nursing and Health Services With Relation to Related Costs.* Abington, Pa., School District of Abington Township, August 1962.

[10] Troop, Eileen H. op. cit., p. 85.

Physicians serve school children in a private capacity as well as through affiliation with public health departments and school systems. Their contributions in free consultative and treatment services have not been surveyed, but they are considerable in communities which lack medical staff assigned to public schools.

PART II—CHAPTER 8

MEDICAL SERVICES

By DONALD A. DUKELOW, M.D., Assistant Director, Department of Community Health and Health Education of the American Medical Association

IN 1878, the house of delegates of the American Medical Association accepted this statement of the physician's role in schools:

> "... medical men ought to have a voice in the construction and location of public school buildings, in the questions as to the age at which children should be admitted, the hours of study, and the general management of these institutions; and to this end it is believed to be necessary that one or more intelligent physicians should be placed on Boards of Education, Boards of Trustees, and other similar boards having control of public education and schools."

Though not the first recognition of a relationship between the physician and the school, it was significant since it came at a time when "medical inspection" of school children was near its inception, the scientific concepts of child development were becoming established, and the beginning of what was to become health instruction was being added to the curriculum.

The physician's relation to the school has evolved during the three-quarters of a century since this pointed resolution was adopted. In addition to his function as a "pupil personnel" specialist, his role includes services and advisory responsibilities to the school faculty and staff, and to the administration responsible for what is called "school health."

The physician is interested in and, to some degree, concerned with the entire area included in the sphere of interest of the Interprofessional Research Commission on Pupil Per-

sonnel Services. Traditionally, his efforts have been centered on certain phases of medical and public health practice, collectively known as the school health program. These include the prevention of physical and emotional deviations—their detection and correction if present—and counsel with allied health and education professions to insure a sound instructional program in the basic concepts of healthful living.

SCHOOL HEALTH PROGRAM

The concept of the school health program encompasses three interrelated areas. Though inseparable, the emphasis given to each varies widely from one school to another. Likewise, the degree of physician interest in each will vary with the personality and experience of the physician and with the amount of freedom he has in advising the school administration.

School health education is defined as the "process of providing learning experiences which favorably influence understandings, attitudes, and conduct in regard to individual and community health." [5]

Healthful school living embraces "all efforts to provide at school physical, emotional and social conditions which are beneficial to the health and safety of pupils. It includes the provision of a safe and healthful physical environment, the organization of a healthful school day, and the establishment of interpersonal relationships favorable to mental health." [6]

School health services include "procedures carried out by physicians, nurses, dentists, teachers, and others to appraise, protect, and promote the health of students and school personnel. Such procedures are designed (a) to appraise the health status of pupils and school personnel; (b) to counsel pupils, teachers, parents, and others for the purpose of helping pupils obtain needed treatment or for arranging school programs in keeping with their abilities; (c) to help prevent communicable diseases; (d) to provide emergency care for injury or sudden sickness; (e) to promote optimum sanitary conditions and to provide proper sanitary facilities; and (f) to protect and promote the health of school personnel." [7]

[5] *Health Education.* Mann, Bernice R.; Southworth, Warren H.; and Reichert, John Lester, editors. Washington, D.C.: National Education Association, 1961, p. 6.

[6] *School Health Services.* Charles C. Wilson, ed. Washington, D.C.: National Education Association, 1964, p. 2.

[7] Ibid, p. 2.

PATTERNS OF PHYSICIAN PARTICIPATION

Every physician who in any way serves the health needs of a school age child or counsels him, his parents, or his teachers regarding any aspect of his physical or emotional well-being, is involved in the school health program. These physicians may be employed by the school or the health department to direct the school health program or perform certain services within it, but the majority are the personal physicians of the pupils.

The private physician is necessarily involved in the school health picture. As the medical adviser to the child and his family, the physician becomes related to the school whenever he advises or cares for the child.

The public clinic physician serves in lieu of a child's personal physician in some communities. This is a frequent practice in metropolitan areas. Here, the relationship between the school and the physician caring for a child is not so close as it otherwise might be, though in many cases the liaison is adequate.

The school physician or school medical adviser has a wide and varied amount of responsibility. Ideally, he is a medical administrator, oriented toward both preventive medicine and education. In a large school system, he is invariably a full-time director with a staff of physicians serving as full-time or part-time consultants. He also directs the work of those in the allied health professions. Sometimes health education and the health aspects of physical education and athletics are within his school health department.

In small school systems where the employment of a full-time school physician is not financially feasible, it is common for a physician in the community to serve as a school physician. In a large proportion of cases this is a gratuitous service, though in some cases a stipend or prearranged fee compensates for part-time service.

School medical advisers who serve in this manner are limited in their services and usually act as physicians for athletic teams, periodically examining pupils who play on the schools' teams. They also perform routine physical examinations of pupils who for some reason do not receive their examinations from personal physicians. In some instances, the school administration may request their counsel on a variety of health problems in the school. If they are compensated on a "per examination" basis, the services outside of examining pupils may not exist.

The community health officer often serves as school physi-

cian. Though common in the smaller, less populous communities, this arrangement also exists in some metropolitan areas. The health officer, himself, or the department's director of maternal and child health, serves as school physician, advising the school administration and directing health service personnel. Usually a school health program which is directed by the health department uses public health nurses to meet the school's nursing needs.

SCHOOL PHYSICIAN'S ROLE

Traditionally, the physician serving the school plans his school health program in accordance with his understanding of school health, the attitude of his school administrator, and the needs of the children.

One of the school physician's important roles is liaison, whereby he interprets the school's impact on children to private physicians. Also, when private physicians request modified school programs for their patients, the school physician interprets these requests to the school and suggests program changes which are compatible with the aims of the school while meeting the needs of individual pupils.

As administrator of the health appraisal program, he instructs teachers on methods of observing changes in the appearance and behavior of children, and directs school nurses and allied health service specialists in the school. He correlates the findings of various physicians who examine children—personal physicians, part-time clinical examiners, or team physicians. Likewise, he correlates physical findings of his medical examiners with opinions of the psychologist and psychiatrist, in order to find the optimum way to handle children with emotional problems. Subsequently, he relates rehabilitation programs for his pupils to the total school activity, including special education if necessary.

The school physician is, in fact, the school health officer and, as such, is concerned with the health of all persons within the entire school environment.

In a metropolitan school district the school physician has a large staff of part-time and full-time physicians and allied personnel. Here the maximum development of the ideal program becomes possible.

SCHOOL PHYSICIAN'S RESPONSIBILITIES

In 1960, a committee of the American School Health Association surveyed the opinion of the Fellows of the Association about school physician responsibilities.

By rating 95 statements of responsibility in terms of their

practicality, desirability, and use, it was learned what physicians, nurses, educators, and others in school health work felt were the activities that should be recommended for the physician serving the school. The responsibilities rated most often in the top 10 ranks stated that the school physician:

Works closely with school nurses to facilitate coordination of the health service program.
Belongs to and participates in National, State, and local medical organizations.
Encourages parents to have their children immunized.
Encourages pupils to have medical examinations done by a family physician when needed.
Assists in planning policies and procedures for emergency care such as for victims of an accident or sudden illness.
Assists and cooperates with school and public health officials in the exclusion and readmission policies of the communicable disease program.
Encourages periodic medical examination of handicapped pupils by family physician or other community resources to determine their physical status.
Participates in or consults with existing local medical societies.
Participates in public health programs to promote the coordination of school and public health programs.

The responsibilities reported as most frequently practiced were the same as the above, with the exception of the first one and the addition of three others:

Performs medical examination of children referred by the teacher or nurse for a specific health problem.
Conducts periodic medical examinations of pupils not examined by private physicians.
Conducts medical examination of athletes.

The responsibilities rated most often in the bottom 10 ranks were:

Immunizes all pupils.
Requests the presence of parents for medical examinations of secondary pupils.
Medically examines all pupils periodically on a predetermined schedule.
Conducts examinations of previously injured or ill pupils before their readmission to school programs.
Periodically studies the medical examination records of all school employees.
Assembles budgetary program for presentation to the school administration.

Likewise, the responsibilities reported as least practiced included all the above, in addition to the following:

Provides consultation concerning healthful school lunch practices.
Assists in recruiting, selecting, and evaluating professional per-

sonnel to be employed in the school health program.
Periodically evaluates the school's adapted physical education program.
Helps to evaluate instructional materials used in health instruction.
Assists with overall planning of adapted physical education.
Assists physical educators in program planning to improve health aspects of physical education.
Assists with inservice education of teachers in the total school and community health program.

Though some of the rarely practiced responsibilities could be considered reasonably desirable, the fact that they were not practiced indicates the characterization of the school physician's role.[6]

In line with this opinion from Fellows of the American School Health Association is the concept of the physician's role expressed by the American Academy of Pediatrics in its statement on school health policies.[7]

[6] Bonnichsen, R. L., and Dukelow, D. A. "Responsibilities of School Physicians," *Journal of School Health*, 31: 21, January 1961.
[7] "School Health Policies"—Report of the Committee on School Health, American Academy of Pediatrics. *Pediatrics*, 24: 6, October 1959.

The Academy of Pediatrics' report is rich in its reference to the team approach to school health services involving at least the parents, nurse, teacher, and physician. This concept is common in the literature on school health practice.

PROFESSIONAL FUNCTIONS AND RELATED EDUCATION OF SCHOOL PHYSICIANS

The American Public Health Association through its Committee on Professional Education has suggested the functions and the professional qualifications for school physicians.[8]

In brief, a school physician should have training in education and public health in addition to medicine. He should be well oriented in child growth and development. Many have specialized in pediatrics. He also should have had the experience of field training or employment under an established school medical director.

PHYSICIAN CONSULTANTS

Most school systems need the consultation of medical spe-

[8] "Educational Qualifications of School Physicians." American Public Health Association Committee on Professional Education. *American Journal of Public Health*, vol. 43, January 1953, pp. 75-82.

cialists. Thus, school health service programs make use of panels of specialized physicians who are coordinated by the school medical director and can be called for advice and guidance in problem areas. These consultants may include opthalmologists, otologists, dermatologists, orthopedists, psychiatrists, and pediatricians.

MEDICAL ASSOCIATION SCHOOL HEALTH ACTIVITIES

Within the past two decades both State and local medical societies have developed considerable interest in the school health program, especially the school health service aspects of the program. In many instances, active committees of physicians work closely with the allied health professions and school administration in formulating policy and desirable practice in school health service.

State medical association interest in the school health program and in child health in general has done much to bring school health work to the attention of local medical societies and the practicing physicians within their area of influence. The 1963 Survey on County Medical Society Activities shows that medical society school health committees occur with greater frequency as the number of members increases. Where membership is 15 or less, only 23.5 percent have school health committees, while societies with 1,500 or more members have such committees in 73.7 percent of instances.[1] Much the same pattern exists for committees on mental health and public health, and maternal and child care, which frequently include school health activities.

Many medical societies place their school health interests in committees identified as health education, child health, maternal and child care, public health, or even interprofessional relations. In a few States, the State medical association and the State department of health are so interrelated that school health interests have been assigned to the department of health as a convenient division of program.

At times, medical societies engage as a group in some school health service function. In programs such as preschool examinations and school health examinations, the smaller societies have a higher rate of participation than the larger ones. This may suggest a closer relation with the school in the rural and small urban communities. On the other hand, larger societies more frequently sponsor conferences on physicians and schools, and sports injuries.

[1] *1963 Nationwide Survey on County Medical Society Activities.* Chicago, American Medical Association, September 1963.

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